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ABSTRACT

This report is designed for use by policymakers and practitioners involved in issues of adult education, welfare reform, and employment training programs. The driving concerns of this report are issues associated with Spanish-speaking adults who are at risk for having learning disabilities. The focus on adults is critical, because such issues as diagnostic requirements and services available are very different for adults with disabilities than for children with disabilities. The ultimate goal of this project is to provide a means to enable persons with disabilities to successfully achieve self-sufficiency through education and work. To develop the needed tools for this effort, a 6-phase project was designed, and this report focuses on the first two phases: reaching a consensus among experts on diagnostic processes for Spanish-speaking adults to determine the presence of learning disabilities (LD); and determining from the existing screen instruments in Spanish which ones should be field-tested to for validity for predicting LD in Spanish-speaking adults. Several specific tests and types of tests are discussed at length. The report is divided into seven sections providing acknowledgements, an executive summary, an introduction, a conference overview, the notes of concern of some participants, findings on the diagnostic process, and screening tool recommendations for field tests. Seven appendices provide details on learning disability definitions, current diagnostic procedures, GED testing requirements, lists of conference participants and project staff. 52 references. (Adjunct ERIC Clearinghouse for ESL Literacy Education) (KFT)

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ED 447 732

LEARNING DISABILITIES AND SPANISH-SPEAKING ADULT POPULATIONS

The Beginning of a Process

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REPORT
ON THE
April 10-11, 2000
CONFERENCE
SAN ANTONIO, TEXAS

Division of Adult Education and Literacy
Office of Vocational and Adult Education
U.S. Department of Education

FL 801412

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- The participants for their time, energy and wisdom in creating the findings for this report.
- Our partners, the National Institute for Literacy and the City of San Antonio - Department of Community Initiatives, for all the support and coordination that went into the planing and staging of the event.
- The several states and national organizations who sent observers and are working with the Department in the development of the field testing process for validation of screening tools.
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- The various states and county governments in Arizona, California, Massachusetts, New York, Texas, and Virginia for committing resources for the next phase of field testing screens.

Please see the appendices for listing of those involved as participants and staff for the meeting.

In addition, there is a need to provide direct thanks to:

- Patricia McNeil, Assistant Secretary, U.S. Department of Education, Office of Vocational and Adult Education (OVAE)
- Ron Pugsley, Director, Office of Vocational and Adult Education, Division of Adult Education and Literacy (DAEL)
- Andy Hartman, Director of National Institute for Literacy (NIFL), and
- Dennis J. Campa, Director, Department of Community Initiatives, City of San Antonio, TX.

Without their support and combined vision, the LD/Spanish effort would not have been able to start.

Sponsoring Partnerships

Office of Vocational and Adult Education (OVAE)

The U.S. Department of Education, Office of Vocational and Adult Education (OVAE), the Division of Adult Education and Literacy (DAEL), is responsible for Title II (Subtitle A) of the Workforce Investment Act, the section known as the Adult and Family Literacy Act. This section of the law addresses adult basic education and literacy education services of State-funded Federal and State support. Parts of the Act require OVAE/DAEL to address the needs of persons who "are unable to speak, write or read English, below a post-secondary level. In addition, the Act requires programs to address the needs or persons with disabilities in adult education. Therefore, OVAE/DAEL has taken the lead in beginning to address the issues for limited English-speakers and learning disabilities (LD).

City of San Antonio – Office of Community Initiatives

The City of San Antonio received a $5,000,000 Welfare-to-Work grant. The goal of the grant, as stated by the Department of Labor, is to target Temporary Assistance to Needy Families (TANF) recipients with disabilities residing in the Edgewood neighborhood (of San Antonio). "This population faces many employment barriers, including an employment and training infrastructure that fails to address special learning and language needs, an intake and assessment process that is not responsive to the needs of persons with learning disabilities, and a lack of job restructuring strategies involving employers to develop current employment and self-employment opportunities." In recognition of the limited tools available to address issues of screening and testing, the Office of Community Initiatives joined the partnership and served as the host city for the meeting.

National Institute for Literacy (NIFL)

National Institute for Literacy (NIFL) is a federal entity created by the National Literacy Act of 1990, with joint oversight responsibilities from the Secretariats of Education, Labor, and Health and Human Services. (As part of the Act creating the Institute, NIFL was directed to address issues of learning disabilities in adults education programs.) NIFL, in response to the mandate, created and funded the National Adult Literacy and Leaning Disabilities Center (1993-99), and currently is funding, in partnership with OVAE, the Learning Disabilities Training and Dissemination Hubs. They also maintain a national list-serve on LD issues through their LINCS internet website. Through its relationships with the three departments, NIFL has made efforts to include LD issues in a wide range of Federal activities.

Executive Summary

The assessment of the cognitive capabilities of individuals from culturally and linguistically diverse populations [is] one of the most difficult tasks facing psychologist today

> Allyn and Bacon in Selective Cross-battery Assessments: Guideline for Culturally and Linguistically Diverse Populations (Intelligence Test Desk Reference (McGraw & Flanagan, ed 1998.),

This report is designed for policy makers and staff, program managers, line staff and practitioners personnel involved in issues of adult education, welfare reform, employment training programs. It is not intended to be a complex "dissertation" on learning disabilities and issues of screening and diagnostic testing. **[As a warning, which we place in all such reports, the information contained within DOES NOT QUALIFY the reader to be able to identify or diagnose learning disabilities.]**

The driving concern of this report is issues associated with Spanish-speaking ADULTS who are at risk for having learning disabilities. The focus on adults is critical since such issues as diagnostic requirements and services available are very different for adults with disabilities than for children with disabilities.

The term learning disabilities (LD) is often misused and misunderstood by the general public. Understanding the term "learning disabilities" is critical as it is used in this report. **Therefore, if the reader has a limited background in the area of learning disabilities in adults it is highly recommended that they begin this document by reading to Appendix I - Learning Disabilities Defined.**

The ultimate goal of this project is to provide means that enable persons with disabilities to successfully achieve self-sufficiency, through education and work, by

- Helping them gain recognition of their disability, in order to access the rights and protections offered them under Federal Civil Rights laws, including access to "reasonable accommodations."

In addition, programs can begin to address the needs of the individual with the disability with appropriate services. For persons with disabilities, services need to incorporate such issues as:

- appropriate instruction, based on research, which addresses the impact of the disability and focuses on consumers strengths,
- assistive technology, to enhance instruction and compensate for the impact of the disability,
- reasonable accommodations, to allow persons with disabilities to fairly compete in testing and work requirements, and
- self-awareness training and advocacy skills on behalf of the consumer, to allow the consumer to independently function in education and work environments.

In order to develop the needed tools for this effort Division of Adult Education and Literacy (DAEL) designed a six- phase project that will involve several years of work. This report focuses

on the steps involved in completion of **the first two phases of** the overall project, and the plans to complete future steps. The steps involved in the whole project are to:

1) Reach consensus among experts on a diagnostic process for Spanish- speaking adults to determine the presence of Learning Disabilities (LD);
2) Determine from the existing screen instruments in Spanish, which screens should be field-tested to test validity of one or more of the screens or screen parts to be a predictor of LD in Spanish-speaking adults;
3) Partner with States and other entities, to field test the screening tools, using a consensus diagnostic process determined as the basis for validity for the screening tools;
4) Evaluate the results of the field testing of the screening tools;
5) Develop reports on the validity of each tool tested, and on the possibility of the development of a new screen based on the findings concerning common questions within the tested screens; and
6) Develop an overall report on the project and its findings.

One question the project has been asked several times is "Why Spanish first?" Immigration into the United States brings people from all over the world. The new populations have literally hundreds of "native tongues." In addition, many Native Americans continue to use traditional languages as their first language. Certain States have indicated needs for support in addressing LD issues for a wide range of languages (other than Spanish).

While the issue of identification of LD is not limited to Spanish-speaking populations, OVAE/DAEL determined to begin the process of development of protocols for LD issues for Spanish-speaking populations first. Spanish was chosen because:

- Spanish-speakers are the largest group of non or limited-English speaking populations in the US, (approx. 75% of the limited English proficient population) and

- From US special education programs, as well as efforts in other countries, a basic foundation of work in Spanish and LD exists on which to build.

In 1997, through previous partnership effort with the Maryland Department of Education, OVAE and NIFL convened a national group of experts in LD and adult education to design an "ideal system" for adults with learning disabilities in adult education (with implications for welfare and job training programs.) This ideal system focused on five key areas:

- Intake (including screening and testing)
- Learner instruction and accommodations
- Instructor training and qualification standards
- Self-advocacy and self-awareness (including medical interventions)
- Community partnerships and collaboration

In employment issues, employer training was added.

With our current knowledge concerning LD and Spanish-speaking adults, the ideal system would be impossible to implement. Our current knowledge and practice is lacking in several areas:

- No national accord on a diagnostic procedure for Spanish-speaking adults.
- No valid LD screening tools standardized on Spanish-speaking adults.
- Not enough information available to properly inform consumers on the issues of LD in order to make the recognition of LD a "positive" event for the consumer.

One of the main concerns of this report is the diagnosis of learning disabilities.
Two models of diagnostics, are in common used, the psycho-educational and neuropyschological. Besides understanding the costs and time required for each testing procedure, an understanding of which type of testing is right for each individual is also important.

The type of testing required for any given adult will be in large part determined by the type of services required and can differ from service to service (such as General Educational Development (GED), college, work, and vocational rehabilitation.)

- Programs in higher education generally accept either a psycho-educational or neurological assessment.
- The GED tends not to accept the neurological assessment alone (because it can be completed without IQ testing.)
- Vocational Rehabilitation tends to require only the neurological testing for the basis of qualification for services, for the impact needs to be employment orientated, not just educationally oriented.

On April 10-11, 2000, a meeting was held of experts in the area of screening and diagnostics for adults who are Spanish speaking and have learning disabilities. Some 31 participants from seventeen states, Puerto Rico and Mexico took part in the effort to address two issues:

1. Determine if there is consensus on a LD diagnostic protocol for Spanish- speaking populations that works for low-income adults populations, and

2. Evaluate and recommend for field testing a number of existing screens for LD in Spanish. (The screen evaluation process used in the model presented in "Bridges to Practice," a LD manual developed by the National Adult Literacy and Learning Disabilities Center.

The conference was held at the Holiday Inn Riverwalk, in San Antonio on April 10-11. After a brief opening session of welcome and brief process of defining of the task of the conference, the conference participants worked in groups, with a final full participant consensus process concluding the work activities.

The profile of the experts included:

- Learning disabilities diagnosticians who work extensively with Spanish speaking adult populations,
- Researchers or educators in the field of LD in non-English speaking populations,
- Professionals in education or work settings involved in disability issues (such as community colleges or Vocational Rehabilitation programs)
- State program administrators

- People in related fields who have a background in LD and ESOL

The participants were divided into two working groups (Red and Blue). The determination of group membership was developed to assure diversity of interests in each of the groups, and with as little redundancy within each group as possible (i.e. the two school psychologists were placed in different groups, the two community college persons were in separate groups, etc.)

The participants were asked to reach consensus on five questions:

1. Under "ideal" settings, and given the current tools available, what tests and procedures would you use for the diagnostic process for LD in adults who are Spanish speaking? On average, how long would this process take? And, on average, what do you think this would cost?

2. Based on the ideal just presented, what are the minimal assessments needed? Please keep in mind the requirements of the GED testing service, The Association on Higher Education and Disability (AHEAD), and other adult focused entities as you determine the minimalist approach. On average, how long would this take, and on average, what do you think this would cost?

3. Can this design be held to be reliable for all persons who are Spanish speaking in the US? Do issues of gender, national origin, number of generations in US, level of literacy and age play too great a variable to make any one approach reliable? If the design can not be held constant, what is required in the way of modification for particular groups?

4. What are the basic requirements concerning the language and cultural background for those conducting the testing?

5. What are other issues and concerns that we need to include, such as consumer involvement or support services during time of testing? What are the critical gaps in research?

Some participants expressed concern that the model that was being advocated was one that extended the diagnostics procedures that exist in the K-12 education system into the adult system. They felt that the K-12 system "hurts" persons with disabilities by:

- Requiring a "label of deficit" prior to providing service,
- The process of identification was slow, costly, and mainly benefited the professionals in the process and not the consumer.
- The services provided assumed that the person could never be competitive and therefore provided very limited services.

There was general agreement among the participants that they would like to eliminate the costly and slow diagnostic process. This could eliminate the bottleneck and costs for as many as 10% of all Americans. However, the group did not, in general, support the "no testing" approach expressed by some. They recognized and for the most part supported current mandates requiring the person seeking accommodations to be able to prove the disability.

Both working groups strongly urged, as part of the process, for programs to be sensitive to the difficulty for the consumer understanding the process, trusting the process, and making adjustments in their daily activities to participate in the testing process. Therefore the groups urged that programs need to:

- Helping the consumer to have an understanding of the testing process (provide information), by
    - Providing bi-lingual/bi-cultural staff persons to support the consumer through a testing process. (Helping to explain issues and procedures.)
    - Developing resources (audio or video tapes of local, respected people explaining the issues and process)
- Attempting to provide the testing in a "safe environment" for the consumer (in their neighborhood, rather than in the psychologist's office)
- Providing for basic needs to attend the testing process and follow-up, such as:
    - A need exists to assess the person's education and medical history to determine if the issues of deficits being expressed were issues of disability or lack of access to education or medical services. The evaluation needed to include:
        - Vision and hearing (Are the issues of learning issues of seeing and hearing?)
        - Basic needs (Was the issue of learning being affected by lack of shelter or food?)
        - Education background (How extensive was the individual's educational background? Was this the first time they were in an educational setting? Were they highly educated but not fluent in English?)
    - Most importantly both groups concluded that the baseline issue that needed to be determined prior to attempting to conduct testing of LD, was:
        - To discover the language comfort and capacity of the individual being testing.

This recommendation for evaluation of language is congruent with the recommendations of The American Educational Research Association's National Council on Measures in Education's Standards for Educational and Psychological Testing (revised 1999).

The group determined that tools were available to evaluate this language comfort and capacity issue.

As noted, few tools are available that are normed on Spanish speaking adults. The main tools recommended for Spanish speaking adults were the:

- The Woodcock Muñoz Language Survey (taking approximately 25 minutes), or
- The Woodcock Language Proficiency Test (taking approximately 45 minutes)

A second test is recommended when the results of the first test are unclear, especially concerning which language to perform the full-scale diagnostic testing.

Another test that was given as an option is the:

- ALAS (Adult Language Assessment Scale)

(These tests must be administered by persons who are LD professionals, or at very least, with oversight by the licensed professional)

❑ LD Diagnostic Testing

As noted, the validated tests that have been normed on Spanish speaking adults are limited. This limitation hampers choice and adds to the cost involved in testing. In addition, almost all tests offered are normed on an American population which can present extensive cultural bias issues in the area of IQ testing

Both working groups felt that the key to determining the diagnostic process was a procedure called "cross-battery testing." This process calls on the types of sub-tests used in diagnostics to be driven by two factors:

- Building on the pretest evaluation (showing the strength of the consumer in various language usage)

and

- Using a principle of redundancy, by which issues or concerns are tested in more than one fashion to determine if it is an issue of language knowledge or an issue of disability.

Both groups reached the decision that the key diagnostic testing tool available for Spanish speaking adults was the Woodcock-Muñoz Psycho-educational Battery or in Spanish, "Bateria Woodcock-Muñoz Revisada." The Cognitive Battery is named "Pruebas de Habilidad Cognitiva" (tests of cognitive ability) and the achievement battery is the "Pruebas de Aprovechamiento" (tests of achievement).

- Administering **all** the sub-tests of the "Pruebas de Habilidad Cognitiva" would involve up to 4 hours of testing.

In addition, to meet the needs of such programs as the GED, and to complete the "deficit" model, there would need to be a full-scale IQ test administered, which, if all the sub tests were administered, would require an additional 3 hours of testing.

- To make the diagnostic process more complete and to meet the needs of all adult programs, additional testing that looks at the neuropsychological aspects of the disability. The main test recommended for this section would be the McCarron-Dial. This would also require three hours of diagnostic testing.

Additionally, time is needed to score the tests, write up the reports (three hours), and to share the reports with the consumer and (with consumer consent) the program, is an additional 2-3 hours.

So, the total time of diagnostic process could be up to 18 hours.

- Pre-diagnostic testing process (2 hours)
- Diagnostic Testing (9-10 hours.)
- Report writing (3 hours)
- Meeting with consumer/program (2-3 hours.)

The groups felt that this level of testing, although inclusive, would be too burdensome for all involved. In addition, the use of the Cross-Battery approach, using particular sub-tests from each battery, that the diagnostic process could be reduced to 11 hours total.

- Pre-diagnostic testing process (2 hours)
- Diagnostic Testing (5-6 hours),
- Report writing (2 hour), and
- Meeting with the consumer (2 hours).

The reported regional cost differences were obvious. They ranged from:

Puerto Rico	$240
Mexico City	$400
Chicago (through a university clinic)	$500
New York City	$1,200 – $3,000
Washington D.C.	$2,000 – $3,500

Multiple ideas were offered to lower costs involved, including the

- use of graduate students to perform all or part of the testing
- use of paraprofessionals to perform sections of the testing
- contracting out large "blocks" of testing to reduce individual costs
- subsidizing the costs through use of welfare or job training funds

Both groups quickly came to relatively the same decision, short cuts are not compatible with good diagnostics. In other words, the level of testing as proposed in answer to the first question was in fact what was needed.

In total, depending on location and resource availability, a "ball park" allocation for testing would be somewhere between $600-900.

Both working groups concluded there is a need for:

- A pre-diagnostic evaluation and testing for language capacity and educational background,
- A correct use of a cross-battery testing strategy that makes use of validated tools, and
- Diagnosticians, who are both culturally sensitive and trained in the cultural issues, involved in cross-cultural testing

Then this process can be held valid to a degree.

Both working groups reached the same conclusion concerning qualifications for a diagnostician.

- The diagnostician should be fluent in the language of the person being tested.
- The diagnostician should also be culturally sensitive to the culture of the person being tested, and if possible from that same culture. (This match of cultures can be very difficult and should be seen as a goal, rather than a complete necessity.)

The group felt strongly that the lack of bi-lingual, bi-cultural diagnosticians was a major problem in development of a functional system.

- The group saw the need to build on the current listing of bi-lingual, bi-cultural diagnosticians developed by the National Association of School Psychologists. It also saw a role in State and local programs investing in recruitment and training of persons to become bi-lingual, bi-cultural diagnosticians.

The groups both found agreement in a wide range of issues concerning consumer empowerment and basic services. These included:

- The need to have a whole system that was bi-lingual and bi-cultural, including intake staff, case managers, job trainers, teachers and counselors.
- The need to address the learning disability issue as an issue of disability and civil rights.
- The need to focus on the skills and abilities of persons with disabilities and not just the deficits created by the impairments
- The need to train the consumers to become self-aware and self advocates concerning disabilities issues.

In addition, persons with LD have the same basic needs for food, shelter, childcare, health care and transportation. Any intervention model for LD needs to be sure that these issues are addressed.

Research

While the group recognized that very little research has been done on LD and Spanish speaking adult populations, and that almost any would be welcomed, they were in agreement on some key concerns that were most important at this time:

1) Considering the risk factors for LD, and the close relationship between poverty and LD risk factors, is there a higher rate of LD in Spanish speaking populations than in the general population?
2) What would an ideal intervention system look like for adults with LD who are Spanish speaking?
3) Can we develop an IQ evaluation that is non-language based and is not culturally biased and normed on adults?
4) Can a screening tool be developed in Spanish for likelihood of LD in Spanish speaking adults?
5) Are there successful "transition models" for youths with LD who are Spanish speaking that can be replicated for adults?

The first task of the Conference was achieved. There was agreement on what a diagnostic process should contain. It involved:

An extensive evaluation of the language, medical and human needs of the consumer using, for the language evaluation:

- The Woodcock Muñoz Language Survey, or
- The Woodcock Language Proficiency test or,
- (ALAS (Language Assessment Scale – Adult version) or
- other valid tests as developed

A diagnostic process conducted in a cross-battery method, by a qualified bi-lingual, bi-cultural diagnostician using appropriate parts of such tests as:

- The Woodcock- Muñoz Psycho-educational Cognitive Battery
- The Stanford-Binet IV or WAIS-III
- The McCarron-Dial for the neuropsychological evaluation

The actual testing part will take about 6 hours, with an additional 5 hours for pre-diagnostic testing process, report writing and meeting with the consumer. The cost will vary based on region and availability of qualified diagnosticians. (Approx. range of $600-$900)

Recommendation for screening tools for field test

The second role of the conference was to recommend, for field testing as many screens which formed some foundation for a successful screen. Seven Spanish-language tools were eventually submitted for consideration.

1) Cooper Screen (private contractor)
2) DRILLS (Dyslexia Research Institute Literacy and Life Skills Program)
3) Washington State Welfare Screen
4) Southwest College (California)
5) Neuropsi (Mexico screening tool)
6) Alabama/Puerto Rico
7) The Adult Learning Disabilities Screening (ALDS - Kansas State LD Screen)

In addition, two other persons, who have developed screening tools for LD in Spanish, were requested to submit their screens for consideration. Both declined. One because of translation problems, and the second due to the need to use a proprietary only computer system to evaluate the result of the screening tool. The owner of the screen could not provide a sufficient amount of computer systems for adequate field testing.

It was agreed that Neuropsi as currently designed would be one of the screens referred for testing.

If Southwest College would modify their screen to only the education section, and add a brief section on work place issues, this screen would be recommended.

If Kansas would address the minor translation issues, and eliminate some of the culturally sensitive questions, this screen would be recommended.

In addition, if Richard Cooper would address the more problematic translations issues and reduce the size of the screen without eliminating the wide range of evaluation (fewer questions per area), the Cooper could be considered.

Therefore, the conference recommended one screen as ready to go (Neuropsi) and two screens which could be ready with relatively little work, (Southwest College, Kansas) and with more extensive work, the Cooper Screen.

INTRODUCTION

The assessment of the cognitive capabilities of individuals from culturally and linguistically diverse populations [is] one of the most difficult tasks facing psychologist today

> Allyn, and Bacon in Selective Cross-battery Assessments: Guideline for Culturally and Linguistically Diverse Populations (Intelligence Test Desk Reference (McGraw & Flanagan, ed 1998.),

Target Audience and Use of this Report

This report is designed for policy makers and staff, program managers and front-line personnel involved in issues of adult education, welfare reform, employment training programs. It is not intended to be a complex "dissertation" on learning disabilities and issues of screening and diagnostic testing. [**As a warning, which we place in all such reports, the information contained within DOES NOT QUALIFY the reader to be able to identify or diagnose learning disabilities.**]

This report is intended to provide an overview of the issues, and help reshape program design to enable the adult education, welfare and employment as well as training systems to begin the process needed to make their programs accessible to persons with learning disabilities, regardless of the language or languages spoken by these individuals.

Key Point - Adult Focus

The driving concern of this report is issues of ADULTS with learning disabilities who are Spanish-speaking. The focus on adults is critical since such issues as diagnostic requirements and services available are very different for adults who have disabilities than children with disabilities. These differences include:

- The adult must have diagnostic testing that meets the guidelines and criteria of "adult programs" (such as the GED testing, college requirements, Vocational Rehabilitation services) not special education requirements as stipulated in the Individuals with Disabilities Education Act (IDEA).

The adult requirements tend to have a higher threshold for qualification than special education. The adult programs often require a demonstration of greater impact, and impacts that are work orientated (in the case of VR). The testing also has to be recent, (in some cases within two years) to meet many program guidelines. (See Appendix 4 for GED Form L-15, for accommodations for LD.)

- Persons with disabilities, once they have a high school degree or reach the age of 22, are not covered under the special education law (Individuals with Disabilities Education Act, IDEA).

The Federal laws concerning civil rights protection of adults with disabilities are the Americans with Disabilities Act (ADA and The Rehabilitation Services Act (Section 504). In addition, with the passage of the Workforce Investment Act (WIA, 1998) the Department of Labor has issued

regulations for ADA/504 compliance for Federally funded employment services programs (Reg. 188).

All of these acts and regulations for adults focus on the issue of "accommodations" and "access" rather than "appropriate education" which is the basis of IDEA.

- Under the adult orientated laws, the persons with disabilities must be able to perform the "essential functions" of the job, with or without accommodations. (Accommodations may include assistive technology, modification to the work environment, extended time on post-secondary or work related standardized testing, etc.)

- Under IDEA, the issue may be that a child with a disability, based on the impact of the disability, **can not maintain the same level of school work as their peers**, or maintain the same standards. IDEA mandates that the schools are still, despite the capacity of the child, required to provide education that is "appropriate." ("Appropriate" is determined by the capacity of the child.)

Therefore, under IDEA requirements and standards can be lowered. Under ADA/504 requirements for work or participation in programs are not lowered, but the person has the right to "reasonable accommodations" and adjustments to "normal procedure" if those adjustments can enable them to be successful in the job or program.

Overall Goal of the Process

The ultimate goal of this project is to provide means that enable persons with disabilities to successfully achieve self-sufficiency, through education and work, by

- Helping them to gain recognition of their disability, and thus enable them to gain access to the rights and protections offered them under Federal Civil Rights laws, including access to "reasonable accommodations."

In addition, through recognition of the disability, programs can begin to address the needs of the individual with the disability and provide appropriate services which addresses the impacts of the disabling condition. For persons with disabilities, the services need to incorporate such issues as:

- appropriate instruction, based on research, which addresses the impact of the disability and works with the consumers' strengths,
- assistive technology, to enhance instruction and compensate for the impact of the disability,
- reasonable accommodations, to allow persons with disabilities to fairly compete in testing and work requirements, and
- self-awareness and advocacy skills on behalf of the consumer, to allow them to independently function in education and work environments.

These steps (along with continued access to medical and transportation services) enable persons with disabilities to become successful and obtain self-sufficiency.

Project Design

In order to develop needed tools for this effort the Division of Adult Education and Literacy (DAEL) designed a six- phase project, which will be implemented over the course of several years. **This report focuses on the steps involved in completion of the first two phases of the**

overall project, as well as talks about the next steps involved in the other steps. These six phases steps are:

1. Reach consensus among experts on a diagnostic process for adults who are Spanish speaking to determine the presence of Learning Disabilities (LD)
2. Determine from the existing stock of screens in Spanish which screens should be field tested to test validity of the screen or screens or screen parts
3. Partner with States and other entities to field test the screening tools, using the consensus diagnostic process determined as the basis for validity for the screening tools
4. Evaluate the results of the field testing of the screening tools and,
5. Develop reports on the validity of each tool tested, and on the possibility of the development of a new screen based on the findings concerning common questions within the tested screens.
6. Develop an overall report on the project and its findings.

Why the Meeting? – Ideal System Breakdown

In 1997, through a previous partnership effort with the Maryland Department of Education, DAEL and NIFL convened a national group of experts in learning disabilities and adult education. The purpose of the meeting was to design an "ideal system" for adults with learning disabilities in adult education (with implications for welfare and job training programs.) This ideal system focused on five key areas:

- Intake (including screening and testing)
- Learner instruction and accommodations
- Instructor training and qualification standards
- Self-advocacy and self-awareness (including medical interventions)
- Community partnerships and collaboration
- In employment situations, employer training.

The main message of the national expert group was that "intake" was the key to any successful program. They stated that "intake" needed to be, in part:

- The cornerstone for the intervention process
- Comprehensive, including a screening process, and if indicated, formal diagnostic procedures.
- Diagnosis tools for LD needed to be appropriate for adults
- The intake should be a highly positive for adults with LD. (helping the consumer to understand that this diagnosis could help them on the road to successful work and self-awareness)

The San Antonio meeting was convened with the understanding that given our current knowledge regarding LD and Spanish speaking adults, the ideal system would be impossible to implement. Our current knowledge and practice is lacking in several areas:

- No national accord on a diagnostic procedure for adults who are Spanish-speaking.
- No valid LD screening tools standardized on Spanish-speaking adults.
- Not enough information available to properly inform consumers on the issues of LD in order to make the recognition of LD a "positive" event for the consumer.

Project Approach

The Division of Adult Education and Literacy (DAEL), in partnership with the City of San Antonio, Office of Community Initiatives, and the National Institute for Literacy (NIFL), developed a three-step process:

1) Convene a national working meeting on issues of diagnostics and screening for LD adults who have Spanish as their primary language.
2) Field-test various screens for LD in selected States, using the diagnostic protocol as the basis for evaluation of the screen's ability to predict LD.
3) Conduct a statistical evaluation of the field tests and issue findings on the predictability of the screening efforts.

This report focuses on the outcome of the first phase of the process: the meeting of experts.

An Important Request – The Need for Background in LD and Issues of Diagnostics

The term learning disabilities (LD) is often misused and very misunderstood by the general public. Understanding of the term "learning disabilities" is critical as it is used in this report. **Therefore, if the reader has a limited background in the area of learning disabilities in adults it is highly recommended that they begin this document by reading to Appendix I - Learning Disabilities Defined.**

Diagnostics – Need for Foundation

One of the main concerns of this report is diagnostics for learning disabilities. This, like the definition of LD, is a complex issue. Again, the reader needs to have some understanding of the ideals and terms used in this process. **Readers who are unfamiliar with the issues involved in LD diagnoses should review Appendix 3 for a description of the testing requirements of GED testing and Appendix 4 for the standards of the Association of Higher Education for Adults with Disabilities (AHEAD).**

Two models of diagnostics, (psycho-educational and neuro-pyschological) are commonly considered. Besides the need to understand the costs and time required for each testing procedure, an understanding of which type of testing is right for what individual is also important.

The type of testing required for any given adult will be in large part determined by the type of services required which can differ from service to service (GED testing, college, work, vocational rehabilitation.) While programs in higher education generally accept either a psycho-educational or neurological assessment, the GED tends not to accept the neurological assessment alone (because it can be completed without IQ testing.) In addition, Vocational Rehabilitation tends to require only the neurological testing for the basis of qualification for services, but the impact needs to be employment orientated, not just educationally orientated.

- Therefore it is possible, based on the type of testing given, and the type of services sought, for a consumer to be recognized as a person with a disability for the purpose of Vocational Rehabilitation Services but not be considered qualified as a person with a disability for the GED testing, or vice versa.

Goals and Participants of the Conference

On April 10-11, experts in the area of screening and diagnostics for adults who are Spanish-speaking and who have learning disabilities was convened in San Antonio, Texas. Some 30 participants from seventeen states, Puerto Rico, and Mexico addressed two issues:

1. Determine if there is consensus on a diagnostic protocol for LD in Spanish speaking populations that works for low-income adults populations, and

2. Evaluate and recommend for field testing a number of existing screens for LD in Spanish. (The screen evaluation process used the model presented in "Bridges to Practice," a LD manual developed by the National Adult Literacy and Learning Disabilities Center.

Two working teams followed a consensus building process in order to reach agreement on both items. The following section provides background on the issues and the consensus reached by the group members.

The profile of the experts included:

- Learning disabilities diagnosticians who work extensively with Spanish speaking adult populations,
- Researchers or educators in the field of LD in non-English speaking populations,
- Professionals in education or work settings involved in disability issues (such as community colleges or Vocational Rehabilitation programs)
- State program administrators
- Professionals in related fields who have a background in LD and ESOL

The Critical Need for Agreement on Diagnostic Process

The partnership (OVAE/DAEL, City of San Antonio and NIFL) sought answers on how to address the needs of both the consumers with LD, as well as State and local programs that serve them. Therefore some of the areas of discussion included:

- The consumer need to be able to understand if a disability is present and if he/she has the right to ask for accommodations.
- The programs need to have a validated tool for screening their clients for LD so they are not faced with the cost of testing all persons, but only referring those consumers with a high indicator of the likelihood of a learning disability.
- Both consumers and programs need to know if the disability is present so together they can develop interventions that include the use of accommodations and assistive technology.

OVAE/DAEL saw the first step towards meeting the needs of both the consumer and the program, was to see if there could be agreement on diagnostics. This agreement was seen as critical for two reasons:

1) For the consumer, to determine the disability for the individual an agreed to diagnostic battery or protocol is needed.

Under Federal law, you can not "assume" a disability. Therefore, for adults to qualify for access to accommodations on the GED testing, in college or on the work site, they must have **validated**

and accepted diagnostic testing that meets the needs of the organizations involved (GEDTS, VR). This is also true for an adult seeking to take citizenship testing.

To date, no widely known or accepted diagnostic procedure is accepted to determine the presence of a learning disability for adults who are Spanish speaking.

2) To validate screening tools a clear determination of what is being identified by the tool is imperative (and therefore an agreement on diagnostics is needed).

It is not possible to validate a screening tool for learning disabilities in Spanish (or any other language) unless there is agreement on how to diagnose LD in that language.

- A "screen" is not a diagnostic tool. A screening tool is only a tool that indicates finding of risk factors. (Is this person someone with a high likelihood of having a learning disability?) The screen is the tool that should lead to referral for full scale diagnostic testing. (Also, like any test, even validated screening procedures will result in some false positives and false negatives. Therefore, screening should be seen a process, with multiple places for consideration for referral, not just as a single tool delivered at only one time.)

In a validation process, diagnostics are used to determine, for a given screen, its rate of false positives and negatives as well as its accuracy in determining the LD. On a very simple level, for a given person, the combination of screening and diagnostic testing provides four options for outcomes:

Question: Does this person have LD?	Screen says:	Diagnostic Test says:	Screen is:
Option 1	Yes	Yes	Valid – Positive
Option 2	Yes	No	False positive
Option 3	No	Yes	False negative
Option 4	No	No	Valid – Negative

By conducting a certain number of screening/testing combinations (referred to in research as the "n") one can determine the rate that a given screen will provide valid information. Without an agreed to diagnostic process that is used universally in the validation process, (all diagnosticians using the same procedures with the same measurement system), the process will be tainted, and no screen or screens would be effectively validated (since each screen would be measure against a different criterion). In addition, avoidance of "selection bias is very important. If the means of selecting people for inclusion in the study is biased towards or from the issue, the study can be tainted. Therefore, one way to avoid selection bias is to use "random selection." For example:

- The people selected for screening must be selected on a random basis, with no preconceived notion of the presence of a learning disability. (Every fourth person on a Tuesday, for example.)
- The screening process should not influence the diagnostic process. The person conducting the diagnostic testing must be different from the person conducting the screening and information on the screening should not be shared with the diagnostician (double blind.)

Therefore, understanding the needs of the consumer and the need of the programs, as well as the requirements for a validation process, a critical outcome of the conference was to try and determine the agreement on a diagnostic process.

Why Spanish First?

Immigration into the United States brings people from all over the world. The new populations have literally hundreds of "native tongues." In addition, many Native Americans continue to use traditional languages as their first language. Certain States have indicated needs for support in addressing LD issues for a wide range of languages (other than Spanish). For example,

- Minnesota has a large Hmong population,
- California has a large Asian and Russian population,
- Arizona and Washington have large Native American populations,
- Washington DC has a large Afghani population,
- Many states have large Haitian communities.

In addition, many areas of the country have experienced a large influx of new immigrants for other regions such as West and Central Asia (Palestinians, Iranians, Pakistanis,) Africa (Nigerian, Ethiopians, South African) and Eastern Europe (Bosnian, Serbs) just to name a few.

While the issue of identification of LD is not limited to Spanish-speaking populations, OVAE/DAEL determined to begin the process of development of protocols for LD issues for Spanish-speaking populations first. Spanish was chosen because:

- Spanish-speakers are the largest group of non-English speaking populations in the US, (approx. 75% of the ESOL population) and
- A basic foundation of work in Spanish and LD (from US special education programs, as well as efforts in other countries) exists on which to build.

The Partnership involved in this project also understands that the term "Spanish Speaking" is not homogeneous. Many variations of Spanish are spoken in the United States, influenced by "nation of origin" and "time in the country."

- For example, discussions at the meeting demonstrated the complexity of the matter by raising the point that the word "tree" is translated differently in Mexico than in Puerto Rico. Similarly the English word "fail" has several different Spanish words that can be appropriately used in translation, but each carries a slightly different meaning.

Even a "language" referred to as "Spanglish" or a combination of English and Spanish, will itself vary from location to location. These language and translation issues add greatly to the complexity of addressing the LD issue, and were addressed during discussions at the conference.

THE CONFERENCE

Selection of Participants

OVAE sent announcements to the State Directors of Adult Education, and through the NIFL list-serve of the requesting participants the conference. In addition, OVAE sought recommendations from other Department of Education offices, and from some of the accepted attendees. The goal was to have the group as diverse as possible, but focused on bringing together persons involved in diagnostic procedures for persons who are Spanish- speaking. Therefore, persons who were running or teaching in adult education programs, but did not have a background in LD, especially in testing for LD, were not accepted as participants. Also a concerted effort was made to bring to the meeting (to the extent possible) persons from the point of origin of the immigrants themselves. Therefore, OVAE discussed participation with persons from Puerto Rico, Mexico, Columbia, Guatemala, Argentina, Spain and those of Cuban heritage.

Eventually, a list was developed of 36 persons who were invited to attend. Out of this list, 31 of the 36 invitees participated in the meeting, 28 from States, 3 from the Commonwealth of Puerto Rico and 2 from Mexico.

Location and Structure

The conference was held at the Holiday Inn Riverwalk, in San Antonio, Texas, on April 10-11. After a brief opening welcoming session and brief description of the process, the conference participants worked in groups, with a final full participant consensus process concluding the work activities.

The participants were divided into two working groups (Red and Blue). Group membership was developed to assure as much diversity of interests in each of the groups, and with as little redundancy within each group (i.e. the two school psychologists were placed in different groups, the two community college persons were in separate groups, etc.

Conference Events

Discussion Questions

The participants' basic assignment was to reach consensus on the five following questions:

1. Under ideal settings, and given the current tools available, what tests and procedures would you use for the diagnostic process for LD in adults who are Spanish speaking? On average, how long would this process take? And, on average, what do you think this would cost?

2. Based on the ideal just presented, what are the minimal assessment requirements needed? Please keep in mind the requirements of the GED testing service, AHEAD and other adult focused entities as you determine the minimalist approach. On average, how long would this take, and on average, what do you think this would cost?

3. Can this design be held to be reliable for all persons who are Spanish speaking in the US? Do issues of gender, national origin, number of generations in US, level of literacy and age play too great a variable to make any one approach reliable? If the design can not be held constant, what is required in the way of modification for particular groups?

4. What are the basic requirements concerning the language and cultural background for those conducting the testing?

5. What are other issues and concerns that we need to include, such as consumer involvement or support services during time of testing? What are the critical gaps in research?

Overview of findings

The participants specified that there was a six- point process for the identification and provision of services for persons who are at risk for LD, regardless of language. The following is an overview of the six points. They are explained in great detail in the discussion section that follows. This process includes:

- Screening, pre-diagnostic testing/interview, diagnostic testing, scoring the tests, reporting the outcomes of the test and implementing the report recommendations.

Comparing the current situation for these issues between services available for English speaking populations and Spanish speaking populations is outlined in the chart on the following page.

Evaluation of the chart shows that:

Screening:

- While some valid English language screens exist, they are not widely used.
- No LD screens have been standardized on Spanish-speaking adults.

Pre-diagnostic testing:

- A pretest for English speakers in language issues is not needed. However, a pre-screen for health issues (vision, hearing) should be conducted to determine if these areas are impacting learning.
- For Spanish speakers, in addition to a pre-test vision and hearing evaluation, the pre-diagnostic testing is critical to determine the language of choice and the skill of the consumer in that language. The Woodcock Muñoz Language Survey and/or, the Woodcock Language Proficiency test, are the recommend tools for the pre-test evaluation of language.

Diagnostic Testing:

- For English speaking populations several normed and acceptable testing tools are in common use, even for adults. (see appendix 2)
- For Spanish, a limited number are normed for Spanish speaking adults. There are also virtually no materials normed on bilingual individuals, who account for many Spanish speaking populations in the United States.

Measuring results of testing:

- For English speakers, the measuring system is well documented. The key discussion in these areas is the use of "regression scales" in helping to address some race, class, age, and gender bias.
- Current Situation:

Intake screen	Pre-diagnostic testing	Diagnostic testing	Scoring process for testing	Reporting process	Implementation process
Some available in validated form in English. Many available in non-validated forms. Limited use in the nation	Tools available, recommended for health and rights issues, but not needed for diagnostic referral, if validated screen used.	Several tools available and normed. General agreement on testing process. (Some question on the quality for low-income and cultural and race.)	Scoring process relatively clear. However, there are questions concerning how age, race, class and gender impacts scoring.	Professionals are increasing including in reports intervention models, rather than simple diagnostic of the disability.	Solid history of implementation through the IDEA and VR system. Far less history of success in the adult education and job training programs
Not available in valid form in Spanish Few available in non-validated forms. Almost no use in the nation	Tools available, Recommended for health issues, Critical to determine language issues.	Limited number of tools available. Not clear agreement of what to use, Limited norming on immigrant populations.	Scoring process less developed on American population. Issues involved same as above, plus time in country, fluency in any language, cultural conflicts.	Limited use of writing of intervention model in report, due to limited intervention model testing.	No history (mainly Puerto Rico) of use of reports in the VR system, and IDEA, almost no history in adult education and job training programs.

- For American Spanish speaking populations the scoring process is less clear, except in the few tests that are standardized for adult Spanish-speakers.

Reporting:

- There has been growing pressure, and increased response, for diagnosticians to provide information in their reports on what types of teaching approaches or reasonable accommodations would be indicated by the tests results
- For Spanish, due to the limited number of tools available, only limited number of reports have these types of recommendations.

Implementation:

- For English speakers, systems have a long history (especially with Vocational Rehabilitation) of being able to transfer the recommendations of the report into a service model. Although in adult education services this has been very limited.

- However, for Spanish speaking populations, this implementation is limited by the lack of history in development of successful intervention models.

The findings of the San Antonio conference supported building ways and means to develop the screens, testing process, evaluation of tests and implementation of the findings into service models.

Note of Concern of Some Participants

Some participants expressed concern that the model that was being advocated was one that extended the process of diagnostics that exist in the K-12 education system into the adult system. They felt that the K-12 system hurts persons with disabilities by:

- Requiring a "label of deficit" prior to providing service,
- The process of identification was slow, costly, and mainly benefited the professionals in the process and not the consumer.
- The services provided assumed that the person could never be competitive and therefore provided very limited services.

Those concerned participants asked for an approach that those who were "struggling" were provided with interventions as needed, not based on expensive diagnostics. An example of how this approach would be designed was provided when one of the participants questioned the requirement that the GED testing be timed at all.

- The participant cited research that showed that extended time does not give those who do not have the knowledge to pass the GED testing, while it does provide some benefit to those who have LD.

The persons raising concerns then asked why can't any one have as much time as they like, since only those with LD would benefit. That would eliminate the need for costly tests and deficit models.

These comments echo the feelings of Richard Figueroa of U. of Cal. Davis (invited but could not attend the San Antonio Meeting) who states:

> The history of special education for Latino students in the United States demonstrates some of the pitfalls of applying "reductionist" philosophies to the educational challenges of underachieving students. He argues that programs need to adopt an "ethnomethodological approach" that emphasizes the social construction of the learning problems.

There was general agreement among the participants that they would like to eliminate the costly and slow diagnostic process. This could eliminate the bottleneck and costs for as many as 10% of all Americans. However, the group did not in general support the "no testing" approach expressed by some. They recognized, and for the most part, supported current mandates requiring the person seeking accommodations to be able to prove the disability.

Findings

Question 1)

Under ideal settings, and given the current tools available, what tests and procedures would you use for the diagnostics process for LD in adults who are Spanish speaking? On average, how long would this process take? And on average, what do you think this would cost?

There was a great deal of agreement in the two groups on the need to incorporate additional steps into the diagnostic process that was not directly expressed by the question presented. These are incorporated in the pre-diagnostic test section in the chart presented above, and they included:

- Meeting Consumer's Basic Requirements

Both groups strongly urged, as part of the process, for programs to be sensitive to the difficulty for the consumer understanding the process, trusting the process, and making adjustments in their daily activities to participate in the testing process. Therefore the groups urged that programs need to:

- Help the consumer to have an understanding of the testing process (provide information), by
  - Providing bi-lingual/bi-cultural staff persons to support the consumer through a testing process. (Helping to explain issues and procedures.)
  - Developing resources (audio or video tapes of local, respected people explaining the issues and process)
- Attempt to provide the testing in a "safe environment" for the consumer (in their neighborhood, rather than in the psychologist's office),
  - Using community based-programs that the consumer is involved with as location for the testing (church, clubs, community centers) and for validation that testing is appropriate.
- Providing for basic needs to attend the testing process and follow-up, such as:
  - Childcare, transportation, formal approval for missing job, training session, etc.

- A need exists to assess the person's education and medical history to determine if the issues of deficits being expressed were issues of disability or lack of access to education or medical services. The evaluation needed to include:
  - Vision and hearing (Are the issues of learning issues of seeing and hearing?)
  - Basic needs (Was the issue of learning being affected by lack of shelter or food?)
  - Education background (How extensive was the individual's education background? Was this the first time they were in an educational setting? Were they highly educated but not fluent in English?)

- Most importantly both groups concluded that the baseline issue that needed to be determined prior to attempting to conduct testing of LD, was:

    - To discover the language comfort and capacity of the individual being testing.

This issue of language is critical for adults who are Spanish speaking for a number of reasons, including:

1. The ability to determine which language would be most appropriate for testing. (While they may be Spanish-speaking they may read and write better in English, or vice-versa.

2. The need to understand if the person being tested is struggling with answers due to disability issues, or simply a lack of understanding of the task being requested.

The discussion can be portrayed in the following graph. In the population being considered, the language capacity could fall under one of the following:

Multi-lingual (speaker of several languages.	Multi-literate (reader of several languages) – all or some of the languages they speak
Multi-lingual	Mono-literate
Multi-lingual	Non-literate
Bi-lingual	Bi-literate
Bi-lingual	Mono-literate
Bi-lingual	Non-literate
Mono-lingual (for this project – Spanish)	Mono-literate
Mono-lingual	Non-literate
Pseudo-lingual (Speaker of a mixed language Spanish and English for example, but not grounded in the grammar of either.	Pseudo-literate (can sight-read key words in both languages, but not fluent in reading either
Pseudo-lingual	Non-literate

This recommendation for evaluation of language is congruent with the recommendations of The American Educational Research Association's National Council on Measures in Education's Standards for Educational and Psychological Testing (revised 1999). Under the chapter "Testing Persons of Diverse Linguistic Backgrounds," it states:

- Standard 9.3: When testing an examinee proficient in two or more languages for which the test is available, the examinee's relative language proficiencies should be determined. The test generally should be administered in the test taker's most proficient language, unless proficiency in the less proficient language is part of the assessment.

- Standard 9.10 Inferences about test taker's general language proficiency should be based on tests that measure a range of language features, and not on a single linguistic skill.

The group determined that tools were available to evaluate this language comfort and capacity issue.

As noted few tools are available that are normed on Spanish speaking adults. The main tools recommended for Spanish speaking adults were the:

- The Woodcock Muñoz Language Survey (taking approximately 25 minutes), or
- The Woodcock Language Proficiency Test (taking approximately 45 minutes)

The second test is recommended when the results of the first test is unclear, especially concerning which language to perform the full-scale diagnostic testing.

Another test that was given as an option is the:

- ALAS (Language Assessment Scale – Adult version)

(These tests must be administered by persons who are professionals in LD, or at very least, with oversight by the licensed professional)

❑ LD Diagnostic Testing:

As noted, validated tests that have been normed on Spanish speaking adults are limited. This limitation hampers choice and adds to the cost involved in testing. In addition, almost all tests offered are normed on an American population which can present extensive cultural bias issues in the area of IQ testing (Also – see the impact of cultural bias on evaluation of screening tools, page x)

In addition, Allyn and Bacon in Selective Cross-battery Assessments: Guideline for Culturally and Linguistically Diverse Populations (Intelligence Test Desk Reference (McGraw & Flanagan, ed.), state that "assessment of the cognitive capabilities of individuals from culturally and linguistically diverse populations" is "one of the most difficult tasks facing psychologist today." They have found that:

> Failure to accurately distinguish normal, culturally based variation in behavior, first and second language acquisition, acculturation, and cognitive development from true disabilities has led to an overrepresentation of individuals from diverse populations in special education and other remedial programs.

Both working groups felt that the key to determining the diagnostic process was a procedure called "Cross-battery testing." This process calls on the types of sub-tests used in diagnostics to be driven by two factors:

- Building on the pretest evaluation (showing the strength of the consumer in various language usage)

and

- Using a principle of redundancy, by which issues or concerns are tested in more than one fashion to try and determine if it is an issue of language knowledge or an issue of disability.

Both groups reached the decision that the key diagnostic testing tool available for Spanish speaking adults was the Woodcock- Muñoz Psycho-educational Battery or in Spanish, "Bateria Woodcock- Muñoz Revisada." The Cognitive Battery is named "Pruebas de Habilidad Cognitiva" (tests of cognitive ability) and the achievement battery is the "Pruebas de Aprovechamiento" (tests of achievement).

- Administering all the sub-tests of the "Pruebas de Habilidad Cognitiva" would involve up to 4 hours of testing.

In addition, to meet the needs of such programs as the GED testing, and to complete the "deficit" model, there would need to be a full-scale IQ test administered, which, if all the sub tests were administered, would require an additional 3 hours of testing.

Some persons believe that all IQ testing is inherently culturally biased. In addition, not all IQ testing have been translated and normed on Spanish speaking populations, and those that have been, leave serious questions with many bi-lingual professionals on validity (due to translation issues). NO IQ test for adults has been normed on Spanish speaking adults in the United States.

- The newest entry into the IQ testing arena with a validated test for the Spanish speaking population is the Stanford-Binet IV. However, since it has not been seen by many of the professionals at the conference, and not available for general use as of yet, there was no consensus as to the quality of the product. This test also requires about three hours to administer all sections.

- Some IQ tests are "non-language" based, such as the Universal Non-verbal Intelligence Test (UNIT). Unfortunately, the UNIT is normed up to age 17 only, and can not be effectively used on adult populations. Other non-verbal tests are the RAVEN (Raven's Progressive Matrices and the TONI, which are both normed on adults, but they only measure one ability and are more like screening tests.

- To make the diagnostic process more complete and to meet the needs of all adult programs is additional testing that looks at the neuropsychological aspects of the disability. The main test recommended for this section would be the McCarron-Dial. This would require some three hours of diagnostic testing.

In addition, time is needed to score the tests, write up the reports (three hours), and to share the reports with the consumer and (with consumer consent) the program is an additional 2-3 hours.

So, the total time of diagnostic process could be up to 18 hours

- Pre-diagnostic testing process – 2 hours
- Diagnostic Testing - 9-10 hours.
- Report writing - 3 hours
- Meeting with consumer/program 2-3 hours.

The groups felt that this level of testing, although inclusive, would be too burdensome for all involved. In addition, the use of the Cross-Battery approach, which eliminates unneeded sub-tests from each battery, that the diagnostic process could be reduced to 11 hours total.

- Pre-diagnostic testing process – 2 hours
- Diagnostic Testing 5-6 hours,
- Report writing - 2 hour and
- Meeting with the consumer - 2 hours.

(The group believed that both the pre-diagnostic testing and the meeting with the consumer were critical and that would not want to reduce it to a level that was meaningless.)

The cost discussion was one of the highlights of the conference. The regional cost differences were obvious. They ranged from:

Puerto Rico	$240
Mexico City	$400
Chicago (through a university clinic)	$500
New York City	$1,200 - $3,000
Washington DC	$2,000 - $3,500

Multiple ideas were offered to the lower costs involved including the:

- by graduate students to performing all or part of the testing
- by paraprofessionals to performing sections of the testing
- contracting out large "blocks" of testing to reduce individual costs
- subsidizing the costs through use of welfare or job training funds

Question 2)

Based on the ideal just presented, what are the minimal requirements needed? Please keep in mind the requirements of the GED Testing Service, AHEAD, and other adult focused entities as you determine the minimalist approach. On average, how long would this take, and on average, what do you think this would cost?

Both groups quickly came to relatively the same decision, short cuts are not compatible with good diagnostics. In other words, the level of testing as proposed in answer to the first question was, in fact, what was needed.

- Both groups indicated that the better the pre-diagnostic evaluation, the fewer tests would be required, and the time and cost needed.

- Both groups felt that the written evaluation and report to the consumer could be reduced to save costs, but could have such a negative impact on the likelihood of consumer success, that the cost savings was not seen as a good risk.

- Both groups did recommend that the use of graduate students and paraprofessionals, as well as contracts for blocks of diagnostics, could reduce the costs involved.

In total, depending on location and resource availability, a "ball park" allocation for testing would be somewhere between $600-900.

In addition, at least five Federal sources have potential for funding of diagnostic testing. Not all persons qualify for the funding, but they should be investigated

1) If the person is under 22 and without a high school degree, special education programs (IDEA) are still responsible for testing, regardless if the person is presently enrolled in school or not.
2) Again, if the persons is under 22, they may qualify for funding through testing through Early Periodic Screening Diagnoses and Treatment (EPSDT) through Medicaid

3) If they are over 16 years of age, Vocational Rehabilitation Services are obligated to perform diagnostic testing, if the potential impact is work related. (This is subject to available resources.)
4) Both Temporary Assistance to Needy Families (TANF) and Welfare-to-Work funds can be used to pay for diagnostic testing.
5) Every state has at least one Federally funded program called University Affiliated Programs (UAP) which provide diagnostic testing services for families at risk (both for children and adults). (Find information in this program at: http://www.aauap.org/)

Question 3)

Can this design be held to be reliable for all persons who are Spanish speaking in the U.S.? Do issues of gender, national origin, number of generations in U.S., level of literacy and age play too great a variable to make any one approach reliable? If the design can not be held constant, what is required in the way of modification for particular groups?

Both groups concluded, that if there is a need for:

- A pre-diagnostic evaluation and testing for language capacity and educational background
- A correct use of a cross-battery testing strategy that makes uses validated tools
- Diagnosticians who are both culturally sensitive and trained in the cultural issues involved in cross-cultural testing

Then this process can be held valid to a degree. The limited tools available make good diagnostic testing difficult and the groups agreed that the need was there to expand our capacity by addressing the limited tools available. While the testing can not be held as valid as for English speaking populations, considering what is available, this system seems to be the best approach.

Question 4)

What are the basic requirements concerning the language and culture background for those conducting the testing?

Both groups reached the same conclusion.

- The diagnostician should be fluent in the language of the person being tested.
- The diagnostician should also be culturally sensitive to the culture of the person being tested, and, **if possible**, from that same culture. (This match of cultures can be very difficult and should be seen as a goal, rather than a complete necessity.)

In addition, since the diagnostician needs to be engaged in the broader system, they need also be English speaking. In other words the diagnosticians need to be:

- Bi-lingual and bi-cultural

It was pointed out in the discussion that there are now court rulings in New York and Virginia requiring bi-lingual and bi-cultural diagnosticians.

The groups were also opposed to the use of translators for testing purpose. This opposition is due to the principle that the tests should be given in the primary language of the consumer. Therefore,

if the diagnostician is not fluent and is relying on a translator for responses, there exists a possibility that the testing may be tainted by translation errors. In addition, "time" is often a consideration in the value placed on an answer given. Working though a translator can impact the "time" factor.

- The groups differed somewhat with the recommendations of the National Council on Measurement in Education.

They do state that "ideally, when ... assessment of individuals with limited proficiency in the language of the test should be conducted by a professionally trained bilingual examiner. When a bilingual examiner is not available, an alternative is to use an interpreter in the testing process and administer the test in the examinee's native language."

- Standard 9.11 states: When an interpreter is used in testing, the interpreter should be fluent in both the language of the test and the examinee's native language, should have expertise in translating, and have a basic understanding of the assessment process.

The group felt strongly that the lack of bi-lingual, bi-cultural diagnosticians was a major problem in development of a functional system.

- The group saw the need to build on the current listing of bi-lingual, bi-cultural diagnosticians developed by the National Association of School Psychologists. It also saw a role in State and local programs investing in recruitment and training of persons to become bi-lingual and bi-cultural diagnosticians.

Question 5)

What are other issues and concerns that we need to include, such as consumer involvement or support services during time of testing? What are the critical gaps in research?

Consumer Involvement: The groups both found agreement in a wide range of issues concerning consumer empowerment and basic services. These included:

- The need to have a system that was bi-lingual and bi-cultural, including intake staff, case managers, job trainers, teachers and counselors.
- The need to address the learning disability issue as an issue of disability and civil rights.
- The need to focus on the skills and abilities of persons with disabilities and not just the deficits created by the impairments
- The need to train the consumers to become self-aware and self advocates concerning disabilities issues.

In addition, persons with LD have the same basic needs for food, shelter, childcare, health care and transportation. Any intervention model for LD needs to be sure that these issues are addressed.

Research:

While the group recognized that very little research has been done on LD and Spanish speaking adults populations, and that almost any would be welcomed, they were in agreement on some key concerns that were most important at this time:

1. Considering the risk factors for LD, and the close relationship between poverty and LD risk factors, is there a higher rate of LD in Spanish speaking populations than in the general population?
2. What would an ideal intervention system look like for adults with LD who are Spanish speaking?
3. Can we develop an IQ evaluation that is non-language based and is not culturally biased and normed on adults?
4. Can a screening tool be developed in Spanish for likelihood of LD in Spanish speaking adults?
5. Are there successful "transition models" for youths with LD who are Spanish speaking that can be replicated for adults?

Summary:

The first task of the conference was achieved. There was agreement on what a diagnostic process should contain. It involved:

An extensive evaluation of the language, medical and human needs of the consumer using for the language evaluation:

- The Woodcock Muñoz Language Survey, or
- The Woodcock Language Proficiency test or,
- (ALAS (Language Assessment Scale – Adult version) or
- other valid tests as developed

A diagnostic process conducted in a cross-battery method, by a qualified bi-lingual bi-cultural diagnostician using appropriate parts of such tests as:

- The Woodcock- Muñoz Psycho-educational Cognitive Battery
- The Stanford-Binet.IV or WAIS-III
- The McCarron-Dial for the neuropsychological evaluation

The actual testing part will take about 6 hours, with an additional 5 hours for pre-diagnostic testing process, report writing and meeting with the consumer. The cost will vary based on region and availability of qualified diagnosticians. (Approx. range of $600-$900)

Section II

Recommendation for screening tools for field test

The second role of the conference was to recommend for field testing as many screens as those at the meeting felt formed some foundation for a successful screen. Seven Spanish-language tools were eventually submitted for consideration.

1. Cooper Screen (private contractor)
2. DRILLS (Dyslexia Research Institute Literacy and Life Skills Program)
3. Washington State Welfare Screen
4. Southwest College (California)
5. Neuropsi (Mexico screening tool)

6. Alabama/Puerto Rico
7. The Adult Learning Disabilities Screening (ALDS - Kansas State LD Screen)

- Five of the screens were direct translations (or attempts at direct translations) of English Language screens in current use (Cooper, DRILLS, Washington State, Alabama and Kansas. Two (Washington State and DRILLS) were translated specifically for the purpose of consideration at this meeting. Two others (Cooper and Kansas) rushed the translation process they had in place to be ready for the meeting.)
- One screen (Neuropsi) was normed on a Spanish speaking population in Mexico.
- Two screens (Washington and Kansas) had been normed on low-income adult populations.
- One screen (Southwest College) was developed for an exclusively for a post-secondary education setting.

In addition, two persons who have developed screening tools for LD in Spanish were requested to submit their screens for consideration. Both declined. One because of translation problems, and the second due to the need to use a proprietary only computer system to evaluate the result of the screening tool. The owner of the screen could not provide enough computer systems for adequate field testing.

Evaluation Process:

The original design of the conference did not call for extensive time to discuss the screening tools. The original design called for participants to rate the tools based on the model for evaluation of screening tools provided by Bridges to Practice.

However, the participants felt they needed an extended period of time to discuss the screens. While the participants did have this time, the facilitators did not have time to confer to assure a similar process in each group's discussions. Consequently a slightly different process was followed by each group, which was then sorted out through the consensus process.

For example, while the Blue group looked at the issue of finding screens that were in-take tools that gave a "binary" response (test or don't test), the Red group looked at the relative values and strengths of each test.

The results of the two group's discussion are as follows;

Screen	Blue Group	Red Group
Cooper	Liked some of the elements including looking at more than reading, but found it too long (45 minutes to administer) and with some major translation problems.	Too long – too education orientated, but looked at many issues, not just reading (good for an assessment of educational needs screen
DRILLS	Too dyslexic focused and the questions did not translate well on a cultural level	Not appropriate for the process
Washington State	While normed on a adult population, creating a screen with weighted questions, it did not work due to cultural issues (some of the most weighted questions would not have meaning to an immigrant populations. i.e. were you in special education)	Too short to be of value other than as a pre-screener. But liked it very much for that role – the ability to be a quick step towards moving the person in the right direction.
Southwest College	Certain sections were very well done, and had a high quality of translation, but it is for an intake process, also too education orientated	Too long and educationally oriented as an up-front screen. Is a good tool for people preparing for higher education, but not for low-level literacy and job programs.
Neuropsi	More designed for neuropsychological evaluation, it was normed on Spanish speaking adults, it could be easily administered. Quick and mainly non-verbal	Seemed not to be appropriate, appeared to require a high degree of training to administer and appeared to take a long time to administer. But normed on Spanish speaking adults Good piece to be used for part of the diagnostics but not part of the screen
Alabama/Puerto Rico	Has some translation issues, but the main problem is that it is a third party screen (not appropriate for an intake tool	Good tool for gaining information from third party as part of the pre-testing evaluation, but not a tool to be used as an in-take screen.
Kansas State	Has some translation problems and some problems with culturally inappropriate questions, but with some help and eliminating some of the questions, could be successful.	Somewhat long and difficult to score, but overall a solid foundation for an intake screening tool.

- So in the first review, it became clear that DRILLS and Alabama were not acceptable to either group.

- After further discussion, in which the cultural issues of the Washington State screen were discussed, it too was dropped from consideration.

Each of the remaining tools was seen as flawed in some way by one or both of the groups. In part, this was a result of the change in format and each group not having the same information (with the writers of some of the tools in different groups).

For example, during the final discussions, the author of Neuropsi, who had been in the Blue group, was able to explain to the Red group, that:

- It was a screen that took no more than 15 minutes
- It was non-language based
- It is being administered in Mexico by semi-literate persons to non-literate persons, and
- It takes less than an hour to train someone to administer the test.

With that additional information, it was agreed that Neuropsi would be one of the screens referred for testing.

In addition, both groups were highly impressed with the translation and quality of the Southwest College screen, but did not know that the college was willing to allow a part of the screen to be used as for field testing.

Recommendations on Screening Tools

After further discussion the group also agreed that:

- If Southwest College would trim their screen down to only the education section, and add a brief section on work place issues, this screen would be recommended.

- If Kansas would address the minor translation issues, and eliminate some of the culturally sensitive questions, this screen would be recommended.

In addition, if Richard Cooper would address the more problematic translations issues and reduce the size of the screen without eliminating the wide range of evaluation (fewer questions per area), the Cooper could be considered.

Therefore, the conference recommended one screen as either ready to go (Neuropsi) and two screens which could be ready with relatively little work, (Southwest College, Kansas) and with more extensive work, the Cooper Screen.

Conclusion:

The conference participants met the stated goals and addressed the central questions posed. This was the first conference on learning disabilities and adults who are Spanish speaking. Through a consensus the process made recommendations for a diagnostic procedure and screens to be field tested.

However, this is just the beginning of the process. The next steps involve implementing the field testing. Currently the Partnership has received pledges of support from some states, as well as some counties to participate in the field testing process. Our goal is to have this field testing and

evaluation of the screens completed in a year to eighteen months. If we can make it sooner we will. OVAE recognizes the need for this project and will work to make it as successful as possible as soon as possible.

Again, thank you to those who have worked with this process to date and those who will join us in the future. Only through these partnerships can the change required come about.

Appendix I
Learning Disabilities:

Definition

Bridges to Practice: A Research-based Guide for Literacy Practitioners Serving Adults with Learning Disabilities lists several definitions of Learning Disabilities. It recommended using the National Joint Committee on Learning Disabilities (NJCLD) definition. As revised in 1994, it reads:

- A learning disabilities is a general term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities.

- These disorders are intrinsic to the individual, presumed to be due to central nervous system dysfunction, and may occur across the life span...

- Although learning disabilities may occur concomitantly with other handicapping conditions (for example: sensory impairments, mental retardation, or serious emotional disturbance) or with extrinsic influences (such as cultural differences, insufficient or inappropriate instruction), they are not the result of those conditions or influences.

In its fact sheet entitled Adults with Learning Disabilities: Definitions and Issues, the National Adult Literacy and Learning Disabilities Center offers the following summary and explanation of the NJCLD's definition:

- There are many variations of learning disabilities.
- Learning disabilities involve difficulties in any of the following skills: listening, speaking, reading, writing, reasoning, and mathematics.
- Social skills may be affected by the learning disability.
- Learning disabilities is due to a central nervous system disorder.
- Although a learning disability may be present with other disorders, these conditions are not the cause of the learning disability.

According to the DSM-IV (the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition), learning disabilities are diagnosed by the use of standardized testing. These tests determine the presence of an LD when those test scores are substantially below those expected given the person's chronological age, measured intelligence, and age-appropriate education.

Types of Learning Disabilities

As stated in the definition, the term Learning Disability covers a wide variety of conditions.

DSM-IV divides learning disorders into four areas:

- Reading Disorders (dyslexia - a severe difficulty in understanding or using one or more areas of language, including listening, speaking, reading, and spelling.

- Mathematics Disorders (dyscalculia –a severe difficulty in understanding and using symbols

or functions needed for success in mathematics)

- Disorders in Written Expression (dysgraphia a severe difficulty in producing handwriting that is legible and written at an age-appropriate speed.)
- Learning Disorders Not Otherwise Specified. (some examples of these other LD issues are:

> Dysnomia. A marked difficulty in remembering names or recalling words needed for oral or written language.
>
> Dyspraxia. A severe difficulty in performing drawing, writing, buttoning, and other tasks requiring fine motor skill, or in sequencing the necessary movements.
>
> Perceptual Handicap. Difficulty in accurately processing, organizing, and discriminating among visual, auditory, or tactile information. A person with a perceptual handicap may say that "cap/cup" sound the same or that "b" and "d" look the same. However, glasses or hearing aids do not necessarily indicate a perceptual handicap.

It should be noted that prior to the term LD (which was first used to describe the disability in 1963, and codified under Federal law in 1967) the term used to define the disability was Minimal Brain Dysfunction (MBD).

Known Causes of Learning Disabilities:
Research indicates that the main causes of LD fall into two categories:

1) Genetics
2) Environmental/Organic/Insults to the System issues.

Through twin studies, as well as other approaches, there appears to be a genetic link for LD. The research on the genetic link is associated with the Human Genome Project and other efforts, and has lead to a great deal of focus on two gene sites (Genes 6 and 15). However, to date, the evidence, while supporting the genetic link, is inconclusive on the specific gene site.

The research connected to environmental issues for causation of LD seem to be more clear in its findings. Researchers report that issues that create "insults to the central nervous system" are the causal factors in LD. These include, birth trauma, low-birth weight, pre-natal exposure to drugs, alcohol, and toxins, as well as prenatal malnutrition. In addition, LD appears to be caused by the impacts of chronic fevers (related to ear infections or other causes), and early child head traumas, as well as early childhood exposure to toxins such as lead.

The environmental research shows that many of the causal factors for LD, are either a direct result of living in poverty (poor diet, increased exposure to toxins,) or exacerbated by issues of poverty (lack of access to medical services for prenatal care and for treatment of fevers and infections).

Rates of Learning Disabilities in the Population:
It is very hard to determine the actual rate of LD in the population. In the 1987 Report to Congress on Learning Disabilities, it was estimated that the rate of LD in the general populations was 5-10%. However, the subsequent longitudinal research (conducted over 10 years, and released in 1997) of the National Institutes for Health, National Institute for Child Health and Human Development found a rate of 17% with reading disabilities alone. NIH's research also

found that 80% of those with LD had a reading disability. Therefore, is 17% represented some 80% of those with LD, the national LD rate would be in the area of about 20% (17%=4/5, than 5/5 = 21.15%) NIH was not saying that all persons with LD had severe LD, but had reading disabilities that, if not addressed effectively at an early age, could result in severe impacts for the individual.

Those receiving services under IDEA (special education) amount to 5.1 per cent of all children, or about 50% of all children receiving special education. However these rates do not include children who have a diagnoses of LD, but are not considered "severe enough" to fit under IDEA guidelines for services. In addition, the IDEA rates do not include those receiving services in schools based on other civil rights laws (i.e. Americans with Disabilities Act, The Rehabilitation Act, section 504) other than IDEA.

In the area of adult education, there has been no national studies conducted to determine the rates of LD in the low-literate adult population. However, studies of welfare populations in Washington State and Kansas (1994-98) found rates of about 40% overall. In addition, the National Adult Literacy Survey, (NALS 1993) found that only 3% of adults self-identified as having a learning disability, but they were highly concentrated in those with very low literacy skills. Of those in Level One (the lowest skill level) 20% reported having a learning disability.

Learning Disabilities and Low-Income Adult Populations:
During the last four decades of focus on learning disabilities, much of the concern has been on children in public schools. The issues of LD in adults have been limited. This was especially true in the area of low-income adults. However, the interest and concerns about learning disabilities in adult populations, especially low-income populations, have grown dramatically over the past decade.

Much of this change occurred with the release of two Federal reports. In 1991, the U.S. Department of Labor, Employment and Training Administration released the report "The Learning Disabled in Employment and Training Programs", and in 1992 U.S. Department of Health and Human Services, Office of Inspector General issued "Functional Impairments of AFDC Clients." Both these reports raised the concerns about the impact of LD on populations trying to achieve self-sufficiency. The reports speculated that the rates of LD in participants in job training programs could be as high as 25%, in welfare programs, as high as 50% and in adult education programs as high as 80%. (As noted above, subsequent pilot projects in Washington State (1994-97) and Kansas (1995-8) confirmed the speculations with findings of LD in welfare populations at about 40%.)

In addition, two of the other key findings of the NIH research helped to restructure our general understanding of LD, and how it could impact adults education as well as welfare. The NIH research found that

- Issues of LD persist into adulthood, and
- There is no gender differential i.e., LD occurs in similar rates in males as it does in females.

These two findings, along with the finding of a 17% rate overall, strongly indicate the reasons why there is such a high rate of LD in persons who have low-literacy skills.

Government's response to date:

The Federal Government's response to issues of LD and adults has included:

- The funding by the National Institute for Literacy (NIFL) of the National Center on Adult Literacy and Learning Disabilities (1995-1999) and
- Funding by NIFL and the Department of Education's Office of Vocational and Adult Education of four "LD Training and Dissemination hubs" to support State efforts in incorporation of LD.
- Inclusion about issues of learning disabilities in the new Federal laws concerning employment training and welfare reform
- The funding a center on disability and welfare policy (HHS, 1998)
- Funding of some 20 Welfare to Work Discretionary Grants with a focus on welfare and disability. (1997-9)
- The staging of a national conference on welfare and disabilities issue sponsored by a number of Federal agencies (May,1999)

Other Federal efforts included several efforts to raise State and local awareness of the issue of adults with LD. For, example, the issue of LD and adult literacy has been an on-going topic of training at meetings of the State Directors of Adult Education.

In addition, several states began efforts to address the issues of LD and low-income adults. Many of these efforts have been supported by the LD center and hubs with technical assistance.

- Both Washington State and Kansas developed validated LD screening tools (1997-8);
- Through the work of the LD center and the LDTD hubs, 41 states have sent teams to receive training in LD issues, based on the training manual Bridges to Practice;
- Rhode Island established a LD screening program for TANF populations through their State VR program;
- Florida funded a pilot project to provide LD specific literacy services to TANF clients;
- Virginia funded 9 pilot cites to develop community based services for TANF clients with LD;
- Georgia plans to test all long-term TANF clients for Learning Disabilities;
- Arkansas is the first State to establish State policy for screening of all TANF clients for LD;
- Texas established pilot projects throughout the State;
- California established a state level LD and TANF taskforce.

LEARNING DISABILITIES AND SPANISH SPEAKING ADULT POPULATIONS

Learning Disabilities and Non- English Speaking Adult Populations.

While these efforts were being taking in the area of learning disabilities and low-income adults the United State experienced a marked increase in immigration. (both legal and illegal) Many of these immigrants sought services from adult education programs, and other human services, to obtain English language training, as well as job training. It is now estimated that 40% of all persons seeking adult literacy services are either immigrants or second-plus generation Americans who are in need of English language training.

As a result of the exposure to training on LD issues conducted by the LD center, the hubs, many of the adult education programs began to recognize that the same issues in "learning to read" that were evident in the LD English speaking populations were also evident in the non-English speaking populations. The program managers and teachers began to ask for assessment tools and

screens for LD, in languages other than English, as well as training on approaches for teaching English to LD non-English speaking populations.

In addition, during this time frame, there has also been a great deal of awareness development in the area of TANF (welfare) and learning disabilities. Again, in States with large immigrant populations, where TANF populations who were non-English speaking made up a large percent, if not majority of welfare populations, State were asking for guidance on how to identify TANF populations with LD and for means to help these clients become successful in work.

The noted pilot projects in Washington State and Kansas led to the development of validated screening tools for TANF populations. However, these tools were normed on English speaking subjects. Therefore, the screens could not be assumed to be reliable for non-English speaking populations. No could it be assured, due to cultural issues, that simple translations of the existing screens would develop a tool in another language that would be an effective as a screen for LD.

Appendix 2 Diagnostic testing for LD

There are two basic forms of diagnostics for learning disabilities

- Educational psychological, and
- Neuropsychological

The educational psychological focuses on the level of achievement of the person versus the level of expectation (based on general intelligence). This is often referred to as the "Discrepancy Model." Therefore, the diagnostic process consists of an intelligence test (or tests) and a series of achievement and performance tests.

The neuropsychological the effort is to measure the "functional" vs "organic" origin of deficit or disorder. The neuro-psychologist tries to diagnose the presence of cortical damage or dysfunction of brain regions and to localize them if possible. This approach does not rely on the differential, but on the issue of the presence of "neurological damage."

While the educational is more designed to see if there is a disorder, with the assumption of the cause being central nervous system disorder, the neruo design attempts to determine where in the system is the causal factor. The testing efforts attempt to do an accurate assessment of cognitive status of a "patient" to plan a rehabilitation or compensation for his deficits.
What is required by the GED Testing Service, is

- For intelligence – the WISC-III, WAIS-III or Stanford-Binet IV
  (other options listed include the PPVT-III, Ravens, TONI, WJ-R (Woodcock Johnson-Revised/Cognitive, KBIT, KAIT)

- For achievement, they recommend the Woodcock Johnson – revised or the WJ-R or the Wechsler Individual Achievement Test (WIAT)

The Association for Higher Education for Adults with Disabilities (AHEAD) has similar guidelines. In the testing guidelines developed in 1997, they recommended the following tests be used.

Aptitude (Achievement)
- Wechsler Adult Intelligence Scale - Revised (WAIS-R)
- Woodcock-Johnson Psychoeducational Battery - Revised: Tests of Cognitive Ability
- Kaufman Adolescent and Adult Intelligence Test
- Stanford-Binet Intelligence Scale (4th ed.)
- The Slosson Intelligence Test - Revised and the Kaufman Brief Intelligence Test are primarily screening devices which are not comprehensive enough to provide the kinds of information necessary to make accommodation decisions.

Academic Achievement
- Scholastic Abilities Test for Adults (SATA)
- Stanford Test of Academic Skills
- Woodcock-Johnson Psychoeducational Battery - Revised: Tests of Achievement
- Wechsler Individual Achievement Test (WIAT)

or specific achievement tests such as:

- Nelson-Denny Reading Skills Test (only for skill level)
- Stanford Diagnostic Mathematics Test
- Test of Written Language - 3 (TOWL-3)
- Woodcock Reading Mastery Tests – Revised

Specific achievement tests are useful instruments when administered under standardized conditions and interpreted within the context of other diagnostic information.

The Wide Range Achievement Test - 3 (WRAT-3) is not a comprehensive measure of achievement and therefore is not useful if used as the sole measure of achievement.

Information Processing

Acceptable instruments include the

- Detroit Tests of Learning Aptitude - 3 (DTLA-3),
- the Detroit Tests of Learning Aptitude - Adult (DTLA-A),
- information from subtests on WAIS-R, Woodcock-Johnson Psychoeducational Battery - Revised: Tests of Cognitive Ability
  as well as other relevant instruments.

Qualified Diagnosticians:

Both GED and AHEAD require that the diagnostics be completed by a professional in the field.

The GED states that the professional must be:

- A psychologist or psychiatrist who "must be certified or licensed to diagnose learning disabilities and/or ADHD. Comprehensive training and direct experience with adolescents and adults populations is required.

The AHEAD guidelines state:

- Professionals conducting assessments, rendering diagnoses of learning disabilities, and making recommendations for appropriate accommodations must be qualified to do so. Comprehensive training and direct experience with an adolescent and adult LD population is essential.... For example, the following professionals would generally be considered qualified to evaluate specific learning disabilities provided that they have additional training and experience in the assessment of learning problems in adolescents and adults: clinical or educational psychologists, school psychologists, neuropsychologists, learning disabilities specialists, medical doctors, and other professionals...

AHEAD also states that

- It is of utmost importance that evaluators are sensitive and respectful of cultural and linguistic differences in adolescents and adults during the assessment process.

Neuropsychologicals focus on areas of brain function, like language, memory, attention, executive functions, visual-spatial functioning, emotional and

motor functions. Neuropsychological assessment is designed to detect subtle problems, and other instruments, like ordinary psychological tests can not.

Neuropsychological assessment represents a comprehensive measure of brain functioning of a subject and measures of social, educational and emotional functioning for a complete prespective of the problem.

Common neuropsychological tests are:

- Halstead Reytan neuropsychological battery.
- Luria Nebraska battery.

BEST COPY AVAILABLE

How to request accommodations using Form L-15

When applying to take the GED with accommodations candidates must get *FORM L-15, Accommodation Request for Learning Disabilities and/or Attention-Deficit/Hyperactivity Disorder.* Form L-15 is available at your local GED office. There is no cost for this form. It is important that you obtain an original copy of Form L-15. The Form has blue coloring and the letter on the first page tears away so that you can retain that information for future reference.

The Cover Letter, Form L-15

Form L-15 begins with a letter that explains how to complete Form L-15. The letter tells what information is needed to document a request for accommodations due to learning disabilities (LD) and/or Attention-Deficit/Hyperactivity Disorder- (ADHD). GEDTS' policy of accommodations conforms to the stipulations of federal laws; i.e. ADA, Section 504 of the Rehabilitation Act, and IDEA. Federal laws mandate that a person with LD and/or ADHD must have documentation from a trained professional in the area of the stated disability that attests to (1) the candidate's cognitive potential to pass the GED or other test or employment position for which application for accommodations is made; (2) the identified disability as it affects information processing or the ability to focus attention; and (3) the significantly negative impact of the documented disability on current academic achievement. To meet the guidelines of federal law, Form L-15 requests this information. Form L-15 must be completed before requesting accommodations. Accommodations will not be granted when the disability is not documented and Form L-15 has not been completed.

If you have a documented learning disability or deficit in attention, it is important that you, or your advocate, follow the directions to complete Form L-15. Do not schedule a testing date until after Form L-15 has been completed and submitted to, and reviewed by, your GED Administrator. If you do not have documentation of a learning disability or ADHD from a qualified professional you will need to get it. For example, a teacher in your adult basic education class may have said you have a different learning style

and provided you with extra time when taking tests in the ABE class. This is a strategy that may help when taking a test but the teacher is not qualified to diagnose a specific learning disability. Testing by professionals with extensive graduate-level training in the fields of LD and ADHD is necessary. Results of this testing are required to document the disability. This testing can be expensive but there are low cost alternatives.

When you have the needed documentation, you may wish to have your ABE teacher, an advocate, your parent, or the professional who diagnosed your disability help you complete Form L-15. When Form L-15 is fully completed, return it to the GED Testing Center. If Form L-15 has not been completed it cannot be processed. If it is fully completed your local GED office will forward your documented, Form L-15 request to the GED Administrator. The administrator will review your application.

The administrator may

- **approve your requests,**
- **approve some of the requested accommodations,**
- **return the request for further information, or**
- **not approve the request.**

You will be sent a letter with the administrator's decision. If your request is not approved, the administrator's letter will explain why the request was not approved. If more information was requested, you may want to consider attaching further documentation such as school records and IEPs or ITPs if you were identified as having a disability while in school. Frequently this information has more data and test scores that can better document your disability so that the GED administrator can approve the request. If you have the needed information resubmit the request to your local GED office. The request will then be forwarded to the GED Administrator for review.

If your requested accommodations have been approved, the GED Testing Center will also be informed and you will be accommodated on the day of testing. If you believe the approved accommodations were not provided you can contact GEDTS by returning to the Accommodating Accommodations web page and clicking the email message or you can call the GED at 1-202-939-9490.

In some cases you may feel that you meet the criteria established and that the GED administrator ruled incorrectly in your case by not approving the requested accommodations. What can you do? There are steps you can follow:

- **GEDTS expert clinical case review**

  You can request an expert clinical case review. To request an expert clinical case review you must submit a letter to the GED Administrator stating the reason for the request. Submit Form L-15 with the supporting psychological and educational reports to the GED Administrator. IEPs and teacher narratives may also be helpful. This gives the expert information necessary to review your request. The expert clinical case review cannot be requested without such supporting information.

  The GED Administrator will send your request to GEDTS in Washington, D.C. The expert who reviews your request will either be a licensed psychologist or an educational expert with similar advanced training. All expert reviewers will have graduate training in the fields of adults with LD and/or ADHD.

When this review is complete, GEDTS will send a response to your request to the GED Administrator. The GED Administrator will forward a copy of the GEDTS expert's review to the candidate. This letter will clearly state the reason for approval or non approval of the request. The clinical expert case review will, in most cases, be completed within 30 days of the receipt of the request for review at GEDTS in Washington, D.C.

- **Appeals panel review**

  If you disagree with both the GED Administrator and the GEDTS expert, and if you obtain a written statement by a licensed expert in the field of LD and/or ADHD discussing clearly why the rulings of the GED Administrator and the GEDTS should be further reviewed within context of GED criteria, the documentation provided, and the mandates of federal laws, you can request a clinical appeal's panel review. This letter must be current and on the professional's letterhead stationery. It must also be signed by the professional. The professional must also provide evidence of certification in this area. In most cases this will be provided by the number of his/her current professional state license to practice.

  A review panel will review the documentation submitted. This panel will be made up of a licensed psychologist with expertise in the area of LD and/or ADHD and an educational expert. Should the two experts disagree a third expert will be asked to review the case. The panel will review the submitted information to determine if the documentation meets GED criteria and the stipulations of federal law. The panel will submit a letter to GEDTS stating whether the accommodations requested should be approved. GEDTS will forward a copy of the letter to the GED Administrator. The administrator will forward the results of the expert appeals panel review to the candidate. The decision of this panel will be seen as the final GEDTS ruling.

To review:

- **Obtain Form L-15.**
- **Complete Form L-15 with the help of your advocate or diagnosing professionals when needed.**
- **Submit completed Form L-15 to your local GED office. Your request as defined on Form- L15 will be forwarded to the GED Administrator from there.**
- **The GED Administrator will review your request and tell you if the request was approved.**
- **If the request was not approved the GED Administrator will explain why not.**
- **If you disagree with the GED Administrator's decision because you believe you meet the criteria identified above, and if Form L-15 was fully complete, you request an expert clinical case review of the GED Administrator's decision by an expert at GEDTS in Washington, D.C.**

- **If you disagree with both the GED state administrator and the expert clinical case review decisions, and if you obtain a written professional reply to the GEDTS' reviews that suggest why further review is necessary, you can request a clinical appeals panel review of your documentation.**

For most candidates when there is a delay in the approval process it is because Form L-15 is not correctly completed. Necessary information is missing. When Form L-15 is not correctly completed it must be returned and the process of requesting accommodations will begin again.

The following pages explain how to complete Form L-15. These pages can help make certain that Form L-15 is correctly completed.

Filling in Form L-15: Form L-15, page 1.

We will now work to complete each section of Form L-15. In this section you will see links that take you to the section of Form L-15 that is being discussed. If you do not have a copy of Form L-15 in front of you refer to those links. The parts of Form L-15 are also listed on the sidebar. You can click the section you would like to review and it will come up on the screen.

Part I: Information

Part I: Section A

GED CHIEF EXAMINER

This section contains information that must be completed by the GED Chief Examiner. The Chief Examiner will fill in all of the information requested. The Chief Examiner will not, however, sign his or her name on Line 7 of Part I until the needed information on Form L-15 is complete. The Chief Examiner cannot send Form L-15 to the GED Administrator if Form L-15 is not complete.

Part I: Section B:

GED CANDIDATE

In Section B candidate information must be provided. This information is necessary so that the testing center can provide needed accommodations during testing to candidates with GEDTS approved requests.

Line 6 of section B. Release of Information

Federal law states that disabilities must be documented. Line 6 is a release of information section that says you give GEDTS permission to obtain and review the needed psychological or educational records. If your record contains information that does not relate to a learning disability and/or ADHD you do not need to submit that information. For example, if you had a significant emotional problem during the past year you do not need to share that information.

Section C: ***page 2***

DOCUMENTING PROFESSIONAL

To the documenting professional.

This section does not request any information. It explains the different roles that professionals will take in providing the needed information.

It is important that the professional who administers the psychological assessment be licensed or certified as someone who is trained to use the required tests. Some of the test information requested on Form L-15 comes from information gained by administering what companies who write the tests refer to as Level C tests. These tests require advanced training. GEDTS must follow their regulations. For this reason your classroom teacher or a counselor cannot administer the test.

If you have test information from when you were in school you can use this if it was done by the school psychologist. School psychologists are certified within each U.S. State to administer such tests.

Certifying Advocate

The certifying advocate is a person who reviews the documentation such as the psychological and educational reports. This person attests to the fact that the documentation seems to support a diagnosis of learning disability or ADHD. This person could be your ABE instructor if you are in an adult education program. The person could be an advocate. The person could also be the psychologist or educational specialist who was part of the diagnostic process.

The section for the certifying advocate is included on Form L-15 to help make certain all the needed information is included before Form L-15 is submitted to the GED Administrator for review. If the needed information is not included on Form L-15, the request will not be processed. It will be returned to you so that it can be completed. This means the process of approving your request will take much longer.

Part II: Disability for which Accommodation is Requested

Part II: Section A:

Specific Learning Disabilities

In this section the specific learning disability (or disabilities) must be indicated. Most will find that the diagnosed disability is one that affects either reading, math or written language. Some may have learning disabilities such as those affecting memory or specific sequential processing. Such learning disabilities will be identified and explained under the category marked as *Other*.

Part II: Section B:

Attention-Deficit/Hyperactivity Disorder.

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Attention Deficit Hyperactivity Disorder (ADHD) can be difficult to diagnose. It is not generally thought to be a learning disability since most believe it is due to a chemical, or neurotransmitter, imbalance rather than an electrical information processing dysfunction that is thought to underlie a learning disability.
Diagnosis of a ADHD requires a developmental history that indicates the presence of ADHD, a DSM-IV code number *(This is the number used by the American Psychiatric Association to define disabilities)*, and a letter from the professional who is making the diagnosis of ADHD.
The letter must clearly state the diagnosis, must attest to the fact that the candidate has the overall potential to pass the GED commensurate with a normed passing rate of 67% of current high school seniors, and must attest to the fact that the ADHD currently, significantly impacts on educational achievement. Some standardized measure of attention, such as a test like the Conners Continuous Performance Test (CPT) should also be reported. Since ADHD is defined as a medical disability, the diagnosis can only be made by a psychiatrist, a physician, a neurologist, or a licensed clinical or school psychologist with advanced training in the diagnosis of ADHD. GEDTS follows this policy carefully. An adult basic educational instructor, for example, may suspect that you have ADHD. That instructor could write a letter stating that you have been successful in the classroom when there are no distractions. Though this letter would be helpful it would not be accepted

as a diagnosis of ADHD. Only a person licensed by a governmental authority to make such a diagnosis can make a diagnosis of ADHD.
When the certifying professional submits a letter it must be on the professional's letterhead stationery. The professional's license number or certification must also be clearly defined.

ADHD is included on Form L-15 because many people who have learning disabilities also have ADHD. Only trained professionals, however, can determine if that is the case. **If the certifying professional is a licensed psychologist who has also completed Part III: Sections B and C of Form L-15, the letter is not necessary. In this case the psychologist would sign Form L-15 in Part II: Section B providing the information requested on the form. A psychiatrist, neurologist or physician could also simply sign and complete Part II: Section B, if Part III: Sections B and C are complete. In this case the psychiatrist, or the advocate, would transfer the information from the psychological and educational reports to Form L-15 in Part III: Sections B and C.**

Part III: Documentation

Part III: Section A:

CLINICAL CASE HISTORY ON FILE

This section seeks to determine if there are psychological and educational reports on file. In the case of an expert or appeals panel review this information would be needed. Included in this information could also be IEPs and ITPs. Medical reports that may be relevant could also be included in the clinical case history. These files remain in a locked file cabinet within the state, provincial, or territorial offices. They are forwarded to GEDTS in Washington D.C. only when a review of the GED Administrator's ruling is requested.

Part III: Section B:

MEASUREMENT OF POTENTIAL OR INTELLIGENCE

Federal law mandates that a person who is accommodated in the work or educational setting must be "otherwise qualified." General definitions of LD

and ADHD include assumptions of average to above average intelligence. For this reason, a candidate requesting accommodations due to LD and/of ADHD must provide documentation of overall potential.
The GED is normed so that 67% of current high school seniors would be expected to pass. This means, in general, one who demonstrates average to above average intellectual potential could be one who is "otherwise qualified" under federal law.

GEDTS, however, views the term of average in the widest range possible under these guidelines. When an IQ of 70 or above is evident, the GED Administrator will review the accommodation request in accordance with the GED screening model. An IQ of 70 is significantly below average and significantly below where one would expect a person to pass the GED based on statistical and research evidence.
When a person has an overall measure below 70, the GED Administrator will forward the request to GEDTS in Washington, D.C. where it will be reviewed by one of the GEDTS experts.

It is important to understand, however, that the GED is not an easy test to pass. It is important to the integrity of the test that it remain normed to the 67% pass rate since it represents an educational attainment equivalent to a high school diploma. Employers and universities accept this equivalency and rely upon the standard that has been set by GEDTS.
The GEDTS policy on documentation has been reviewed extensively by experts in assessment, learning disabilities, ADHD, disability law, and advocacy. It has also been reviewed by the U.S. Department of Education and the U.S. Department of Justice.

<u>Primary measures of intelligence</u>

- **Wechsler Intelligence Scales**
- **Wechlser Intelligence Scale for Children-Revised, WISC-R;**
- **Wechsler Intelligence Scale for Children-Third Edition, WISC-III;**
- **Wechsler Adult Intelligence Test-Revised, WAIS-R;**
- **Wechsler Adult Intelligence Test-Third Revision, WAIS-III);**
- **Stanford Binet Intelligence Scale-Fourth Revision (SB-IV)**

<u>Supporting, or secondary, measures of intelligence include:</u>

- **Kaufman Adolescent and Adult Intelligence Test (KAIT)**
- **Kaufman Brief Intelligence Test (K-BIT)**
- **Woodcock-Johnson Psycho-Educational Battery-Revised:Tests of Cognitive Ability(WJ-C)**
- **Peabody Picture Vocabulary Test-Revised (PPVT-R)**
- **Test of Nonverbal Intelligence-Revised (TONI-R)**
- **Ravens Progressive Matrices**
- **Slosson Intelligence Test**
- **Detroit Tests of Learning Aptitude-Revised-Adult (DTLA-R)**

Test Scores

It is important to look carefully at what information is being requested!

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Date of Assessment

In this line the date given on the psychological report should be used. At the beginning of most reports it has a line that states "Date of Testing, or Date of Assessment." Many times more than one testing day was necessary. Testing, however, was done on two days that were very close to each other. Put in the most recent date of testing.

The date of assessment is important. GEDTS realizes that LD and ADHD are lifelong disabilities and that current retesting of intellectual potential is not always necessary. The following conditions apply to the date of assessment:

- **Testing must be a current reflection of adult cognitive functioning.** ***This means that a 40 year-old person who was tested when s/he was 20 using the WAIS-R could submit that report as an indication of overall potential and patterns of relative information processing strengths and weaknesses. If, on the other hand, a person of 20 submitted test scores from when s/he was 7 years-old, those scores could not be accepted as an indication of current adult cognitive functioning.***
- **If a person has testing from childhood using a test such as the WISC-R or WISC-III, while a preferred adult test would be the WAIS-R or WAIS-III, a secondary supporting current update of intellectual potential could be provided.** ***Thus if a person has a report that includes WISC-III subtests scores current supporting testing could use the WJ-C, for example.***
- **If testing from childhood only contained a statement of IQ but gave no further data, a new current WAIS-III would be required to document the patterns of relative information processing strengths and weaknesses.**

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Check Test Used

This section asks for the name of the test of intellectual assessment that was used to diagnose the learning disability. One of the primary measures of intellectual potential defined above must be checked. Those tests are listed in this section with a box beside them. Check the correct box.

Below the box the form requests information about the Intelligence Quotients (IQ). In the appropriate box give the Verbal IQ the Performance IQ and the Full Scale IQ. Without these scores, the GED Administrator must return Form L-15 and request further information. When Index scores, such as the Verbal Comprehension Index Score, are provided these should be included as well. These scores help GEDTS better understand the nature of the specific learning disability and/or ADHD.

All IQ and Index scores are presented as standard scores. This means that an average IQ score is 100. There is a standard deviation of 15 for most IQ tests. This means that a significant discrepancy would be defined if there were a difference of 15 points between index scores of the verbal and performance IQs. The GEDTS model, however, is more inclusive than the 15-point discrepancy.

Subtests Scaled Scores

The next section requests information about subtest scores. When a Wechsler Intelligence Test is used there are subtest scores that have a mean of 10 and a standard deviation of 3. These subtest scores present patterns of relative strengths and weaknesses and are important in the diagnosis of LD and/or ADHD. The subtests are listed on Form L-15. The scores for the subtests must be provided on Form L-15.

Some psychologists do not administer all subtests when giving a test such as the WAIS-III. Some of the subtests listed do not apply to all of the Wechsler tests. Those subtests administered; i.e., those subtests for which scaled scores are provided, must be included on Form L-15.

If the SB-IV test is used, IQ and SB-IV index scores can also be used to document the nature of the disability. These scores must be provided on Form L-15.

The psychologist or educational specialist will know how to complete the test score section of Form L-15.

Other supporting documentation

This section requests information on any other intelligence tests that may have been given. These tests are listed above under the supporting, or secondary tests, of intelligence. Such tests may be administered to update previous testing. They could also be administered to better demonstrate potential in a specific area, such as nonverbal intelligence.

This section may also include other testing that more clearly defines the nature of the information processing deficit.

Tests of Information Processing include:

- **Bender Gestalt Test of Visual-Motor Abilities**
- **Test of Written Language- Revised (TOWL-R)**
- **Tests of memory; eg., WRML**
- **Tests of auditory processing; e.g., Wepman Test of Auditory Discrimination**
- **Many other tests of specific information processing capabilities exist. They would also be reported in this section of Form L-15.**

Many candidates will not have further testing. In this case this part of Form L-15 will remain blank.

Psychological Diagnostician

This section provides information about the psychologist who administered the psychological evaluation. Understanding how to give and interpret intelligence tests takes advanced training. Test companies refer to tests such as the Wechsler Intelligence Scales as Level C tests. They require Ph.D level training and licensure before a person is permitted to purchase and administer the tests in private practice. It is important, therefore, that GEDTS makes sure that a qualified person administered the tests which are used to document the LD and/or ADHD.

Psychologists within public school systems have been certified by the school system. They have had supervised training in the school system. If testing was done by a psychologist within the school system while the candidate was attending school in that system, no licensure or Ph.D. is required. Many governments also license school psychologists in private practice to do psychological testing. These psychologists usually have an advanced degree in school psychology. Other states provide certification to such psychologists. Depending upon the guidelines of each individual state, province or territory, GED requires certification or licensure information for those professionals who are in private practice.
In all cases, certification or licensure of the professional must be current and the area of specialization must relate to LD and/or ADHD.

The final notation at the bottom of page 4 asks whether a discrepancy or standard score model is used to determine placement for LD in the public school systems from which the candidate's request comes. This section can be left blank if the information is unknown.

Part III: Section C:

MEASUREMENT OF CURRENT EDUCATIONAL ACHIEVEMENT

In this section information about current educational achievement is requested. Achievement tests of education are designed to measure what has been learned as a result of exposure to learning experiences both in school and in general. Since the GED is a test that documents a high school level of learning, achievement tests that document reading, math and written language ability are necessary to document a learning disability. These tests assist in defining the nature of the learning disability and in insuring that appropriate accommodations are provided. Since accommodations could also actually interfere when they are not correctly provided GEDTS wants to be certain that all accommodations provided, are relevant to a candidate's documented disability.

Information about current educational achievement information is obtained from well-standardized educational tests that have norms and standard scores. Those tests approved by GEDTS as primary measures of educational achievement are standardized and normed on diverse national populations. These tests also have been found to be valid and reliable.

Since it is important to know how a documented disability currently negatively impacts upon academic achievement, GEDTS requires that the educational test results be relatively current; i.e, within the last two years.

Since GEDTS is concerned that testing of educational achievement provide a clear picture of current educational achievement so that *appropriate* accommodations can be provided, specific tests are listed as primary, acceptable tests of academic achievement. Standard test scores, based on age norms, must be provided in the blank spaces provided on Form L-15. Many of the achievement tests are written for children. If one of the tests listed below was not included in previous educational testing, scores from this test must now be included in Part III, Section C.

Primary measures of educational achievement

- **Woodcock-Johnson Psycho-Educational Battery-Revised (WJ-R)**
- **Wechsler Individual Achievement Tests (WIAT)**
- **Scholastic Abilities Test for Adults (SATA)**
- **Stanford Tests of Academic Skills**
- **Kaufman Tests of Educational Achievement (K-TEA)**
- **Peabody Individual Achievement Tests-Revised (PIAT-R)**
- **Bateria Woodcock-Munoz-Revisada**

Secondary (or supporting) tests of educational achievement.

- **Wide Range Achievement Test- Revised or Third edition (WRAT-R, WRAT-III)**
- **Nelson Denny Reading Skills Test**
- **Woodcock Reading Mastery Tests-Revised(WRMT-R)**
- **Key Math Tests revised**
- **Tests of Written Language-3 (TOWL-3)**
- **Stanford Diagnostic Mathematics Test**

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Section C first asks for the date of educational testing and the name of the test used. This information must be provided.
The form then asks for the standard broad reading, math and written language scores. These are standard scores. Standard scores have a mean of 100. This means the scores in the blanks should be a number above or below or at 100. Percentile scores or grade equivalent scores should not be written in these blanks.
Looking at this section you will see that each broad area is broken down into sections. Often the person who administered the educational test will provide these scores as well. These can be very important in documenting LD and/or ADHD. If only the broad scores were given, however, it is not necessary to go back to the person who administered the test to obtain the individual scores; e.g., the score for word identification. If there is other supporting educational testing, include it in the appropriate space. Again please write in the standard scores.

Educational or Psychological Diagnostician

Most frequently an educational specialist will administer the educational tests. It is important that this person be someone who is trained in the area of LD and/or ADHD. Not all educational specialists will have certification. Psychologists also administer the educational tests when they administer the psychological tests. They can also administer them even though they have not recently given the assessment of overall intellectual potential. Psychologists are licensed or certified. The person who administers the educational assessment completes Line 5 of Section C.

Part IV: Accommodations

Part IV: Section A:

SPECIFIC INTERVENTIONS

This section seeks information about what kinds of accommodations were made due to your disability when you were in school or in your work setting. If a teacher has suggested a particular learning strategy that has been helpful, you may also want to explain that in this section as well.
If you were not diagnosed as having LD or ADHD while in school or previously at work, this section may be left blank.
If you were not previously diagnosed, but a current instructor has suggested effective learning strategies that seem to work for you, you may want to include them here.

Part IV: Section B:

STATEMENT OF NEEDED ACCOMMODATIONS

In this section it is important to define how the diagnosed disability relates to the currently requested accommodations. Here evidence from past accommodations that have worked as well as test scores and previous special educational placements should be included.

Accommodations

This section lists the approved GEDTS accommodations. Those accommodations that relate specifically to the diagnosed disability should be checked. For example, if a math disability were identified a candidate might request extended time on the math test and the use of a calculator. A suggestion that the candidate would be anxious when taking the test and thus need a private room and breaks would not relate to a diagnosed disability that significantly negatively impacts. Many people could be expected to be nervous or anxious when taking a test. This is not, in general, a dehabilitating disability significantly different from what one would expect of most people.

- **Extended time: most find that 1-1/2 normal time is sufficient extra time. Double time or triple time can, however, be requested if diagnosis and presented information supports this time request. Those who want to take tests on separate days must contact their local GED Testing Center. GEDTS does not approve this request.**
- **Audiocassette: Candidates who request the use of the audiocassette need to request a practice test using the audiocassette. The GED uses a tone indexed audiocassette. For some this can be difficult to use without prior experience.**
- **Scribe: The scribe must be a person provided by the GED center. This person records all of the responses of the candidate.**
- **Calculator: The calculator is useful for those who may have difficulty aligning math problems in basic calculation steps. It is not as helpful for those who have difficulty reasoning how to do a math problem.**
- **Frequent breaks: When frequent breaks are requested the amount of time for the breaks and the amount of time taking the test must be specified.**
- **Other: In some cases GEDTS provides other accommodations when it is clear that a very significant disability, such as cerebral palsy that can limit both the written and spoken word, is defined.**

Because of test security issues and the cost of development of a new test should security be violated, word processors and computers are not accommodations included on Form L-15. These are not reasonable accommodations. The new GED tests that will be released in 2002 are looking at ways to make these forms of accommodations possible.

Some test taking strategies that have been effective in the past do not require GEDTS approval. Large print editions of the GED can be requested by all who take the GED. Persons who use a straight edge or colored overlays to help with reading may bring these to testing. Their use does not require GEDTS approval. If you prefer to sit, for example, by a window you may request such a seat. If space permits the GED examiner will try to fulfill your request. It is important, however, to check with the GED examiner prior to the use of any strategies to be certain that they are within GEDTS guidelines.

Checklist

The top of page 6 provides a checklist. It is important that the checklist be reviewed before submitting a request for accommodations due to LD and/or ADHD. An incomplete Form L-15 must be returned for the needed information. This will significantly slow the review process.

Official Use Only

The final section of Form L-15 is for use only by the GED Administrator. In this section the administrator, using a Level 1 screening review of a request for accommodations, makes a determination of what accommodations are to be provided.

This page maintained by Kathleen Ross-Kidder, Ph.D., Department of Psychology, The George Washington University; Psychological consultant to GEDTS

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Appendix 4 The Association on Higher Education And Disability (AHEAD) GUIDELINES

GUIDELINES FOR DOCUMENTATION OF A LEARNING DISABILITY IN ADOLESCENTS AND ADULTS

July 1997

The Board of Directors established an Ad Hoc Committee to study issues surrounding the documentation of a learning disability. The Board wishes to thank the members of the *AHEAD* Ad Hoc Committee on LD Guidelines for their efforts in laying the foundation of these Guidelines for use by the Association's members.

Loring Brinckerhoff

Ad Hoc Committee Chairperson

Educational Testing Service

Recording for the Blind and Dyslexic

Joan McGuire

Ad Hoc Committee Liaison to the Board

University of Connecticut - Storrs

Kim Dempsey

Law School Admission Council

Cyndi Jordan

University of Tennessee - Memphis

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Harvard University

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Guidelines for Documentation of a Learning Disability in Adolescents and Adults

Introduction

In response to the expressed need for guidance related to the documentation of a learning disability in adolescents and adults, the Association on Higher Education And Disability (*AHEAD*) has developed the following guidelines. The primary intent of these guidelines is to provide students, professional diagnosticians and service providers with a common understanding and knowledge base of those components of documentation which are necessary to validate a learning disability and the need for accommodation. The information and documentation that establishes a learning disability should be comprehensive in order to make it possible for a student to be served in a postsecondary setting.

The document presents guidelines in four important areas: 1) qualifications of the evaluator, 2) recency of documentation, 3) appropriate clinical documentation to substantiate the learning disability, and 4) evidence to establish a rationale supporting the need for accommodations.

Under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, individuals with learning disabilities are guaranteed certain protections and rights of equal access to programs and services; thus the documentation should indicate that the disability substantially limits some major life activity. The following guidelines are provided in the interest of assuring that LD documentation is appropriate to verify eligibility and to support requests for accommodations, academic adjustments and/or auxiliary aids. It is

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recommended that postsecondary institutions using these guidelines consult with their legal counsel before establishing a policy on documentation relating to individuals with disabilities. In countries not regulated by this legislation further modification may be appropriate.
These guidelines are designed to be a framework for institutions to work from in establishing criteria for eligibility. It is acknowledged that different educational settings with different student populations will need to modify and adapt these guidelines to meet the needs and backgrounds of their student populations.

Recommendations for consumers are presented in Appendix A to assist them in finding and working with a qualified professional in regard to documentation.

Documentation Guidelines
I. Qualifications of the Evaluator
Professionals conducting assessments, rendering diagnoses of learning disabilities, and making recommendations for appropriate accommodations must be qualified to do so. Comprehensive training and direct experience with an adolescent and adult LD population is essential.

The name, title and professional credentials of the evaluator, including information about license or certification (e.g., licensed psychologist) as well as the area of specialization, employment and state/province in which the individual practices should be clearly stated in the documentation. For example, the following professionals would generally be considered qualified to evaluate specific learning disabilities provided that they have additional training and experience in the assessment of learning problems in adolescents and adults: clinical or educational psychologists, school psychologists, neuropsychologists, learning disabilities specialists, medical doctors, and other professionals. Use of diagnostic terminology indicating a learning disability by someone whose training and experience are not in these fields is not acceptable. It is of utmost importance that evaluators are sensitive and respectful of cultural and linguistic differences in adolescents and adults during the assessment process. It is not considered appropriate for professionals to evaluate members of their families. All reports should be on letterhead, typed, dated, signed and otherwise legible.

II. Documentation
The provision of all reasonable accommodations and services is based upon assessment of the impact of the student's disabilities on his or her academic performance at a given time in the student's life. Therefore, it is in the student's best interest to provide recent and appropriate documentation relevant to the student's learning environment.

Flexibility in accepting documentation is important, especially in settings with significant numbers of non-traditional students. In some instances, documentation may be outdated or inadequate in scope or content. It may not address the student's current level of functioning or need for accommodations

because observed changes may have occurred in the student's performance since the previous assessment was conducted. In such cases, it may be appropriate to update the evaluation report. Since the purpose of the update is to determine the student's current need for accommodations, the update, conducted by a qualified professional, should include a rationale for ongoing services and accommodations.

III. Substantiation of the Learning Disability
Documentation should validate the need for services based on the individual's current level of functioning in the educational setting. A school plan such as an individualized education program (IEP) or a 504 plan is insufficient documentation, but it can be included as part of a more comprehensive assessment battery. A comprehensive assessment battery and the resulting diagnostic report should include a diagnostic interview, assessment of aptitude, academic achievement, information processing and a diagnosis.

A. Diagnostic Interview
An evaluation report should include the summary of a comprehensive diagnostic interview. Learning disabilities are commonly manifested during childhood, but not always formally diagnosed. Relevant information regarding the student's academic history and learning processes in elementary, secondary and postsecondary education should be investigated. The diagnostician, using professional judgment as to which areas are relevant, should conduct a diagnostic interview which may include: a description of the presenting problem(s); developmental, medical, psychosocial and employment histories; family history (including primary language of the home and the student's current level of English fluency); and a discussion of dual diagnosis where indicated.

B. Assessment
The neuropsychological or psycho-educational evaluation for the diagnosis of a specific learning disability must provide clear and specific evidence that a learning disability does or does not exist. Assessment, and any resulting diagnosis, should consist of and be based on a comprehensive assessment battery which does not rely on any one test or subtest.

Evidence of a substantial limitation to learning or other major life activity must be provided. A list of commonly used tests is included in Appendix B. Minimally, the domains to be addressed must include the following:

1. Aptitude
A complete intellectual assessment with all subtests and standard scores reported.

2. Academic Achievement
A comprehensive academic achievement battery is essential with all subtests and standard scores reported for those subtests administered. The battery

should include current levels of academic functioning in relevant areas such as reading (decoding and comprehension), mathematics, and oral and written language.

3. Information Processing
Specific areas of information processing (e.g., short- and long-term memory, sequential memory, auditory and visual perception/processing, processing speed, executive functioning and motor ability) should be assessed.
Other assessment measures such as non-standard measures and informal assessment procedures or observations may be helpful in determining performance across a variety of domains. Other formal assessment measures may be integrated with the above instruments to help determine a learning disability and differentiate it from co-existing neurological and/or psychiatric disorders (i.e., to establish a differential diagnosis). In addition to standardized tests, it is also very useful to include informal observations of the student during the test administration.

C. Specific Diagnosis
Individual "learning styles," "learning differences," "academic problems" and "test difficulty or anxiety," in and of themselves, do not constitute a learning disability. It is important to rule out alternative explanations for problems in learning such as emotional, attentional or motivational problems that may be interfering with learning but do not constitute a learning disability. The diagnostician is encouraged to use direct language in the diagnosis and documentation of a learning disability, avoiding the use of terms such as "suggests" or "is indicative of."

If the data indicate that a learning disability is not present, the evaluator should state that conclusion in the report.

D. Test Scores
Standard scores and/or percentiles should be provided for all normed measures. Grade equivalents are not useful unless standard scores and/or percentiles are also included. The data should logically reflect a substantial limitation to learning for which the student is requesting the accommodation. The particular profile of the student's strengths and weaknesses must be shown to relate to functional limitations that may necessitate accommodations. The tests used should be reliable, valid and standardized for use with an adolescent/adult population. The test findings should document both the nature and severity of the learning disability. Informal inventories, surveys and direct observation by a qualified professional may be used in tandem with formal tests in order to further develop a clinical hypothesis.

E. Clinical Summary
A well-written diagnostic summary based on a comprehensive evaluation process is a necessary component of the report. Assessment instruments and

the data they provide do not diagnose; rather, they provide important elements that must be integrated by the evaluator with background information, observations of the client during the testing situation, and the current context. It is essential, therefore, that professional judgment be utilized in the development of a clinical summary. The clinical summary should include:

1. demonstration of the evaluator's having ruled out alternative explanations for academic problems as a result of poor education, poor motivation and/or study skills, emotional problems, attentional problems and cultural/language differences;

2. indication of how patterns in the student's cognitive ability, achievement and information processing reflect the presence of a learning disability;
3. indication of the substantial limitation to learning or other major life activity presented by the learning disability and the degree to which it impacts the individual in the learning context for which accommodations are being requested; and

4. indication as to why specific accommodations are needed and how the effects of the specific disability are accommodated.
The summary should also include any record of prior accommodation or auxiliary aids, including any information about specific conditions under which the accommodations were used (e.g., standardized testing, final exams, licensing or certification examinations).

IV. Recommendations for Accommodations
It is important to recognize that accommodation needs can change over time and are not always identified through the initial diagnostic process. Conversely, a prior history of accommodation does not, in and of itself, warrant the provision of a similar accommodation.

The diagnostic report should include specific recommendations for accommodations as well as an explanation as to why each accommodation is recommended. The evaluators should describe the impact the diagnosed learning disability has on a specific major life activity as well as the degree of significance of this impact on the individual. The evaluator should support recommendations with specific test results or clinical observations.

If accommodations are not clearly identified in a diagnostic report, the disability service provider should seek clarification and, if necessary, more information. The final determination for providing appropriate and reasonable accommodations rests with the institution.

In instances where a request for accommodations is denied in a postsecondary institution, a written grievance or appeal procedure should be in place.

V. Confidentiality

The receiving institution has a responsibility to maintain confidentiality of the evaluation and may not release any part of the documentation without the student's informed and written consent.

APPENDIX A

Recommendations for Consumers

1. For assistance in finding a qualified professional:
* contact the disability services coordinator at the institution you attend or plan to attend to discuss documentation needs; and
* discuss your future plans with the disability services coordinator. If additional documentation is required, seek assistance in identifying a qualified professional.
2. In selecting a qualified professional:
* ask what his or her credentials are;
* ask what experience he or she has had working with adults with learning disabilities; and
* ask if he or she has ever worked with the service provider at your institution or with the agency to which you are sending material.
3. In working with the professional:
* take a copy of these guidelines to the professional;
* encourage him or her to clarify questions with the person who provided you with these guidelines;
* be prepared to be forthcoming, thorough and honest with requested information; and
* know that professionals must maintain confidentiality with respect to your records and testing information.
4. As follow-up to the assessment by the professional:
* request a written copy of the assessment report;
* request the opportunity to discuss the results and recommendations;
* request additional resources if you need them; and
* maintain a personal file of your records and reports.

APPENDIX B

Tests for Assessing Adolescents and Adults

When selecting a battery of tests, it is critical to consider the technical adequacy of instruments including their reliability, validity and standardization on an appropriate norm group. The professional judgment of an evaluator in choosing tests is important.

The following list is provided as a helpful resource, but it is not intended to be definitive or exhaustive.

Aptitude
* Wechsler Adult Intelligence Scale - Revised (WAIS-R)
* Woodcock-Johnson Psychoeducational Battery - Revised: Tests of Cognitive Ability
* Kaufman Adolescent and Adult Intelligence Test
* Stanford-Binet Intelligence Scale (4th ed.)

The Slosson Intelligence Test - Revised and the Kaufman Brief Intelligence Test are primarily screening devices which are not comprehensive enough to provide the kinds of information necessary to make accommodation decisions.

Academic Achievement

* Scholastic Abilities Test for Adults (SATA)
* Stanford Test of Academic Skills
* Woodcock-Johnson Psychoeducational Battery - Revised: Tests of Achievement
* Wechsler Individual Achievement Test (WIAT)

or specific achievement tests such as:

* Nelson-Denny Reading Skills Test
* Stanford Diagnostic Mathematics Test
* Test of Written Language - 3 (TOWL-3)
* Woodcock Reading Mastery Tests - Revised

Specific achievement tests are useful instruments when administered under standardized conditions and interpreted within the context of other diagnostic information. The Wide Range Achievement Test - 3 (WRAT-3) is not a comprehensive measure of achievement and therefore is not useful if used as the sole measure of achievement.

Information Processing

Acceptable instruments include the Detroit Tests of Learning Aptitude - 3 (DTLA-3), the Detroit Tests of Learning Aptitude - Adult (DTLA-A), information from subtests on WAIS-R, Woodcock-Johnson Psychoeducational Battery - Revised:

Tests of Cognitive Ability, as well as other relevant instruments.

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